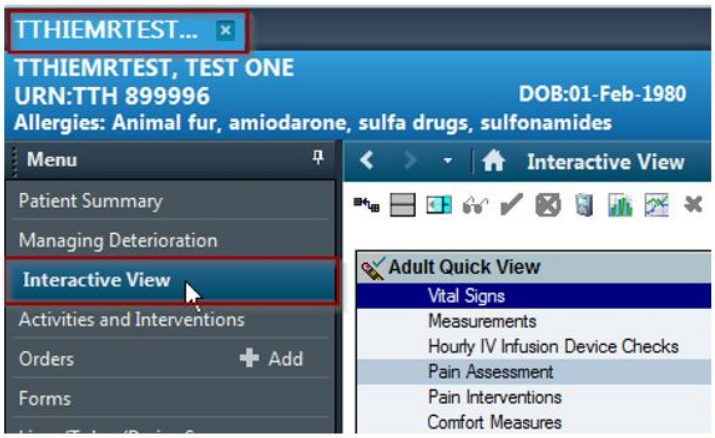
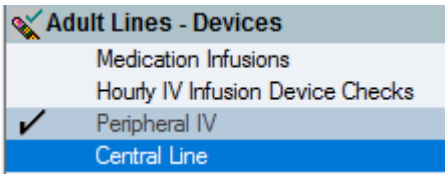
Documenting a Central Venous Catheter (CVAD /CVL)

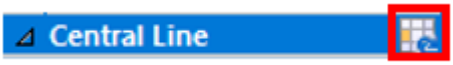
1. Open the patient's chart and go to *Interactive View* from the menu on the left-hand side



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*

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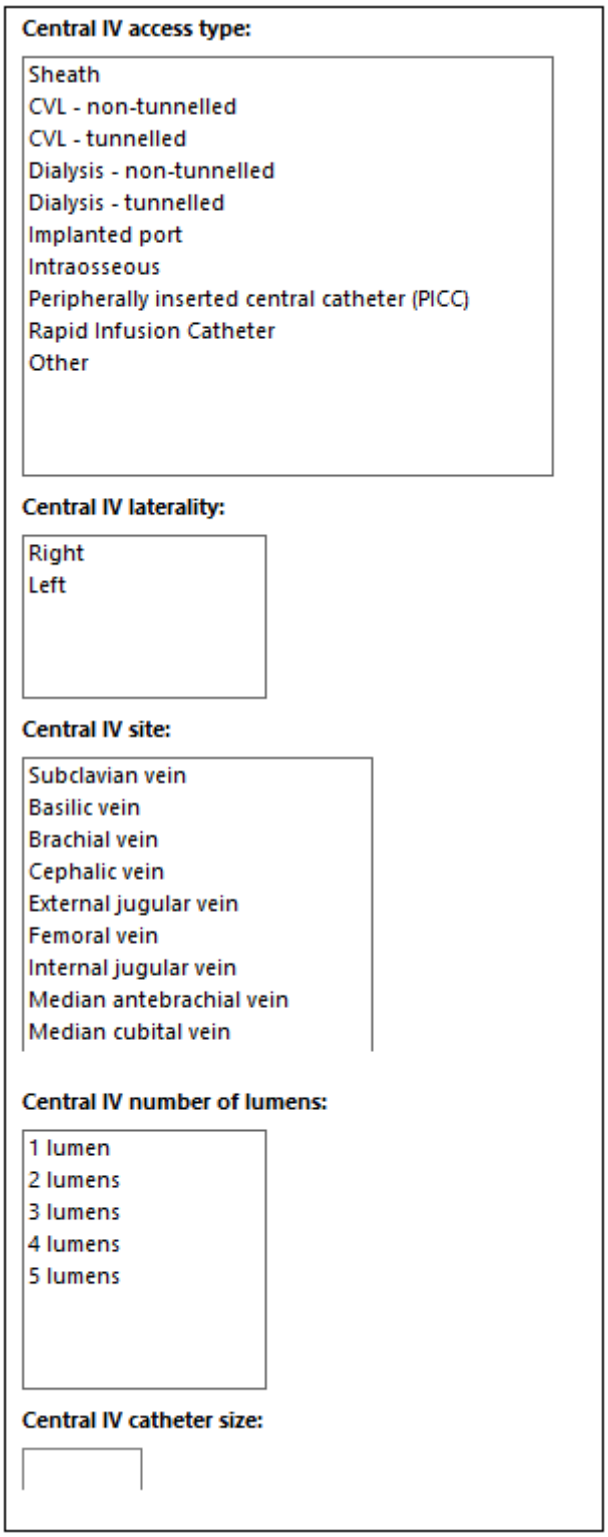


Central IV access type:

- 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:

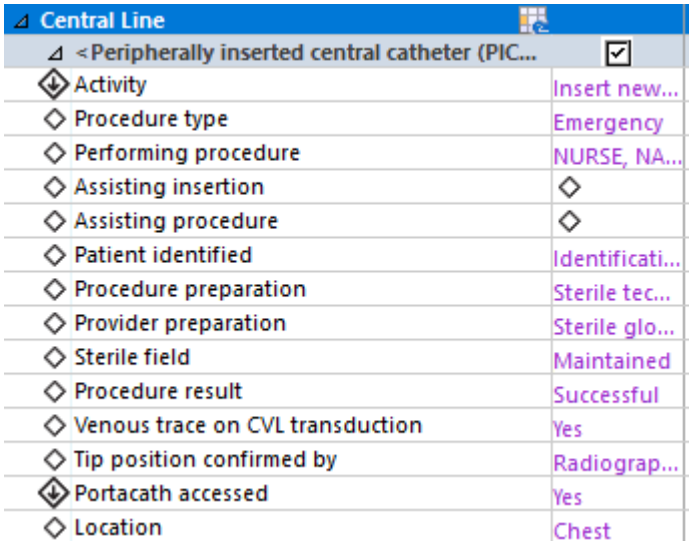
Documenting a Central Venous Catheter (CVAD /CVL)

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.

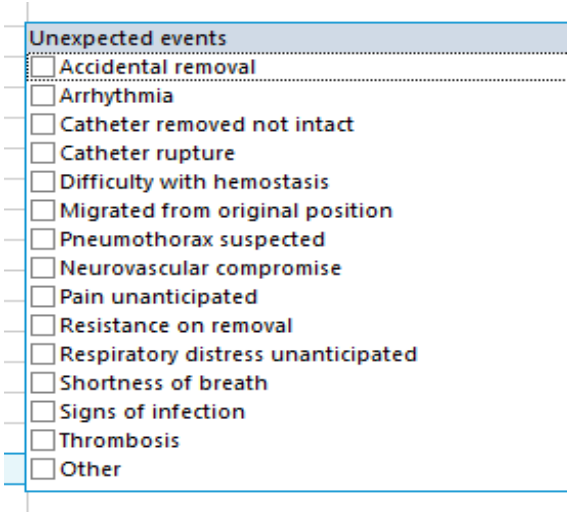
As a minimum, the following information should be entered:

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



11. Enter unexpected events if applicable

Documenting a Central Venous Catheter (CVAD /CVL)



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

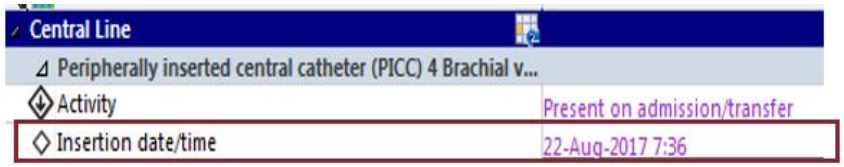
Documenting a central venous catheter that your patient already has insitu (e.g. another department such as OT or ICU have inserted the central venous catheter but not documented in *PowerChart)*.

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

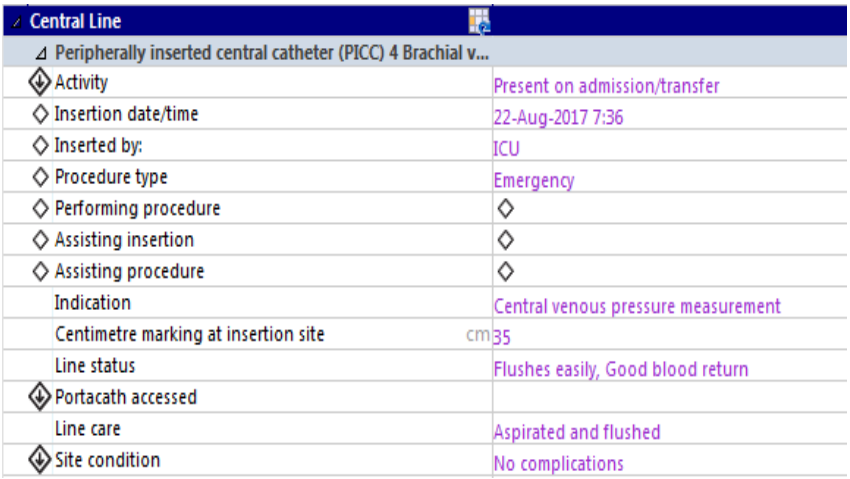
As a minimum, the following information should be entered:

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)

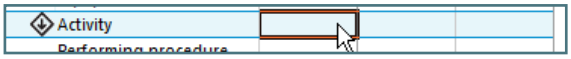


3. If known, document location of insertion (e.g. ICU, ED)
4. Document line status and care
5. Once you have entered your data click sign to finalise your entry.

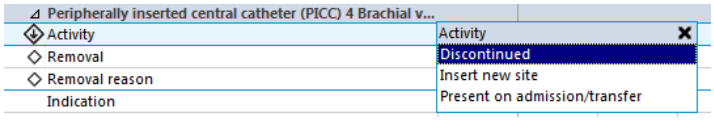


Documenting Removal of a Central Venous Catheter

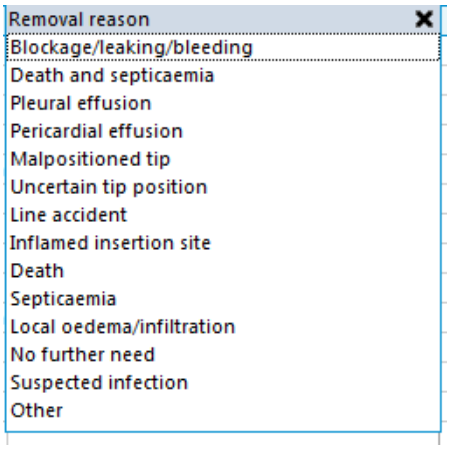
1. Click on the cell next to *Activity.*



2. A menu will open.



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



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