The Clatterbridge Cancer Centre NHS Foundation Trust

PATIENTS CENTRAL VENOUS ACCESS DEVICE (CVAD) HAND HELD RECORDS

This information pack is for patients who have a CVAD inserted at The Clatterbridge Cancer Centre. A CVAD includes a Peripherally Inserted Central Catheter (PICC), Totally Implanted Venous Access Device (TIVAD) or a Skin Tunnelled Catheter.

The patient has been asked and is encouraged to present this pack every time they attend each hospital visit and to present it to the district nursing team managing the device in the community.

The purpose of the pack is to develop a log of care for all health care professionals caring for the patient.

Summarised Essentials

1. A **full aseptic technique** using surgical ANTT is required every time a line is redressed in every care setting, including when accessing and de-accessing a TIVAD
2. The distal portion of a PICC line, when not in use, should be secured with a single piece of sterile gauze (for comfort) and fully sealed inside a transparent dressing, as per instructions on the dressing guide. Dressings are not normally required once a TIVAD insertion site has fully healed and sutures removed. For patients who have a skin tunneled line, dressings are not required once sutures have been removed; patients may request a dressing and Biopatch. A disinfectant end cap should be used on skin tunneled catheters.
3. All line care and assessments **must** be documented in this record
4. TIVAD removals can be arranged if necessary with the interventions team. All line removals need to be recorded for audit purposes.
5. Blood pressure readings should be taken on the opposite arm to the PICC/Peripheral TIVAD. If this is not possible the cuff should be applied on the lower arm or alternatively use the leg, but never across the device
6. 0.9% Sodium Chloride only for routine line flushes, Hepsal is not required. A pulsatile method should be adopted when providing maintenance or end flush completing with positive pressure to maintain patency.
7. Every effort should be used to conserve a line; therefore a line should be used to administer IV antibiotics for suspected infections, and should be used if a thrombus is confirmed/suspected to reduce the incidence of line failure.

The Clinical Interventions Team can be contacted directly on 0151-556-5737 or bleep 4095 Monday-Friday 8-6 for line related problems.

For any urgent advice contact the CCC Hotline 0800 169 5555, available 24 hours a day

CENTRAL LINE INSERTION/MANAGEMENT RECORD

Patient's Name: Date of line insertion:
Ward/Dept: Consultant
NHS/CCC Number:
Date of Birth: Line inserter:

Type of line inserted: please circle and document version

PICC: Skin tunnelled line: TIVAD: Peripheral/Chest

.....

Reason for line: Please circle:

PVA: specific chemotherapy regime: IV access: venous sclerosis: Other (please specify)

.....

Anticipated period device will be required…….

Risks discussed with patient including: **Thrombus** **Infection** **Failure of line**

Informed consent gained: **Leaflet given to patient:** **Bloods checked by inserter:**

Confirm full sterile procedure using: **Packs, CHG 2%, Drapes, Gown, Mask/Cap** - **YES/NO**

Screening swabs YES/NO please circle: **MRSA/CPE/VRE** Not necessary **TIVAD Pre-assessment**

Vein selected: Number of attempts: Problems during insertion YES/NO

……..……..……..

Securacath: YES/NO if no please specify……Length line cut to…… Length of line at exit site:…... **Pocket closure**: Subdermal & Subcuticular suture to close with Steri-strips to secure

Size of Huber needle to be used:…… Tip position:……

ECG tip location technology used YES/NO CXR required YES/NO Fluoroscopy used: YES/NO

CXR length after x-ray: Documented in records that line can be used:

Where initial dressing change arranged:..... Where line maintenance arranged:.....

Referred to D/N: YES/NO Biopatch/AG: YES/NO **Wound check appointment given**:…….

Guidelines, D.N prescription, flushing equipment & dressings for two visits given to patient: YES /NO

If no specify reasons _____

Pack given to patient and advised to take to all hospital visits: YES/NO. Immediate wound check following TIVAD insertion:…… **Discharged as planned**: YES/NO

Visual Infusion Phlebitis (VIP) Scoring Tool for Intravenous Access Device (VIIAD)

Exit site appears healthy	⇒ 0	**No sign of phlebitis** Observe PICC/CVAD exit site
One of the following is evident: Slight pain near exit site Slight redness near exit site	⇒ 1	**Possible first signs of phlebitis** Continue to observe IV catheter
Two of the following are evident: Pain at exit site Swelling Erythema	⇒ 2	**IMPORTANT** **Seek advice VIP score 3-5** Mon-Fri between 8am and 6pm Ring the Clinical Interventions Team on 0151 556 5737 or bleep 4095 Out - of - hours ring the CCC Hotline on 0800 169 5555
All of the following are evident: Pain along the IV catheter Erythema Swelling	⇒ 3	
All of the following are evident and extensive: Pain along the path of the IV catheter Erythema Swelling Palpable venous cord	⇒ 4	
All of the following are evident and extensive: Pain along the path of the IV catheter Erythema Swelling Palpable venous cord Pyrexia	⇒ 5	

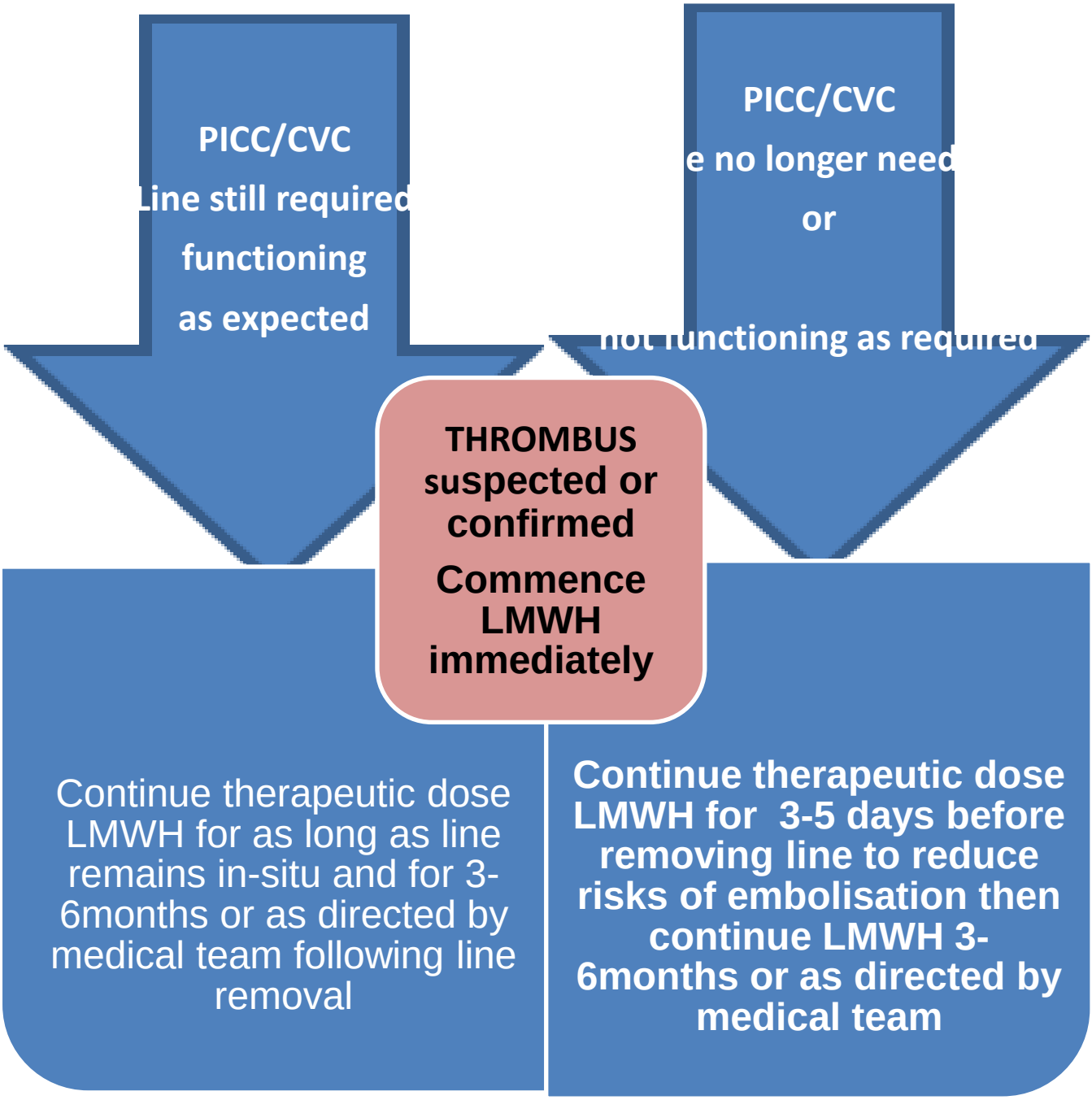
Patients will often be asked to attend their local A/E urgent care centres. Please use this advice to help guide care. Every effort should be taken to conserve vascular access and should be used to achieve relevant IVABX treatment within the hour targets

- ✓ **Management of suspected exit/pocket site infection**. Assess area for redness or exudate, if present swab for microbiology confirmation of infection. Assess for systemic symptoms, treat exit/pocket site problems as cellulitis with broad spectrum oral/IV antibiotics which may need to be altered depending on microbiology results – **Continue to maintain the line**, DO NOT REMOVE

- ✓ **Management of suspected line infection**. Assess patient for systemic sepsis - take peripheral blood cultures first then immediately take PICC cultures aseptically to avoid contamination of samples, ensure ACCURATE labelling. **REMEMBER** full septic screen for other focus of infection if patient neutropenic. IV antibiotics when prescribed are best administered **via** the line. Vancomycin is often prescribed for line infections to help conserve the line, particularly if venous access is poor and that it is impossible to administer elsewhere. If patient remains pyrexial and unwell after 96hours of the correct microbiology guided antibiotic therapy it may be necessary for the line to be removed – until then the line should be **used** and maintained correctly. DO NOT REMOVE ROUTINELY
- ✓

Management of thrombus. If patient attends with a suspected thrombus (swollen arm, dilated chest veins, discoloured "line arm") order a Doppler Ultrasound to confirm thrombus. If **positive DO NOT** remove the PICC/TIVAD; commence treatment dose LMWH. The patient should be assessed for improvement of symptoms following commencing therapy in the chemo clinics during treatment visits; **the line should be used as normal**.
Only when the line is no longer required or not functioning, commence LMWH and administer for at least 3-5 days to reduce risks of embolisation before the line removal.

Algorithm for the management of Upper Extremity Deep Vein Thrombosis (UEDVT)


PICC/CVC
Line still required
functioning
as expected
PICC/CVC
e no longer need
or
not functioning as required
THROMBUS suspected or confirmed
Commence LMWH immediately
Continue therapeutic dose LMWH for as long as line remains in-situ and for 3-6months or as directed by medical team following line removal
Continue therapeutic dose LMWH for 3-5 days before removing line to reduce risks of embolisation then continue LMWH 3-6months or as directed by medical team

Patient's name:
NHS/CCC number: Reason for line: Allergies:

PICC dressings require the distal portion of the line to be fully covered when not in use at home.

ALL lines require a **positive pressure flush** with10ml 0.9%sodium chloride which is essential to maintain patency during flush and when de-accessing a TIVAD.
For PICC's always document the exit length every visit to monitor for migration.

Dressing and Flushing Record - please complete all sections on all visits:

Date	VIIAD/ VIP score Exit length	Dressings Used	Blood yielded	Saline flush	Anticipated removal date	Printed name
TIVAD ONLY Please ensure that steri-strips remain in place until pocket wound confirmed as established.						

Lines placed using ECG showing the tip position is within the SVC and is safe to be used.

Confirmed by: **NAME**---------- **SIGNATURE**----------

Comments: For actions taken to manage line, dressings or alterations to the care plan:

Call CIT: 0151 556 5737 for training or advice. Pocket wound established – Date _____ Signed _____

Patient's name:

NHS/CCC number: Reason for line:

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Call CIT: 0151 556 5737 for training or advice.

Removal record

Patients name: CCC number:

Date of line insertion: Date of line removal:

Appointment date for removal of TIVAD/skin tunnelled line:

Bloods checked prior to TIVAD/Tunnelled line removals YES/NO Anaesthetic used:…….

Reason for line removal;

If line removed prior to treatment completion please document the attempts taken to conserve the line if appropriate.

Clinic where the line was removed:

Is a replacement line required?

Name of person removing line:

All removals should be added onto the patients' Meditech records.