Policy for the Insertion and Management of Peripheral Venous Cannula (PVC)

KEY POINTS

- SCOPE – To ensure standardisation of practice in terms of Peripheral Venous Cannulation
- CIRCULATION - All staff involved in the insertion and management of PVCs in the clinical area
- PURPOSE - To reduce the incidence of catheter related blood stream infections in the Trust in conjunction with the Department of Health Targets.

KEY CHANGES

- Complications of PVC during and post insertion
- Appendix of flow rates and cannula positions
- Port cleansing solution
- Cannulation packs

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Ratified Date: 26.5.2011
Ratified By: TIPC
Review Date: November 2011
Accountable Directorate: Infection Control
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Table of Contents

1 Circulation .............................................................................................................................. 5
2 Scope ..................................................................................................................................... Error! Bookmark not defined.
3 Definitions ............................................................................................................................... 5
4 Reason for Development ...................................................................................................... Error! Bookmark not defined.
5 Aims and Objectives .............................................................................................................. 6
6 Standards ................................................................................................................................. 6
   6.1 General ................................................................................................................................. 6
   6.2 Development of Policies and Procedures ........................................................................ Error! Bookmark not defined.
   6.3 Ratification of Policies and Procedures ........................................................................... Error! Bookmark not defined.
   6.5 Monitoring of Policies and Procedures .......................................................................... Error! Bookmark not defined.
   6.7 Retirement of Policies and Procedures .......................................................................... Error! Bookmark not defined.
7 Responsibilities ...................................................................................................................... Error! Bookmark not defined.
   7.1 Individual Responsibilities .............................................................................................. Error! Bookmark not defined.
   7.1.1 Chief Executive ............................................................................................................... Error! Bookmark not defined.
   7.1.2 Director of Governance and Standards ................................................................ Error! Bookmark not defined.
   7.1.3 Executive Directors ...................................................................................................... Error! Bookmark not defined.
   7.1.4 Policy and Procedure Owners .................................................................................. Error! Bookmark not defined.
   7.1.5 Gatekeepers ................................................................................................................ Error! Bookmark not defined.
   7.1.6 Healthcare Governance Team .................................................................................. Error! Bookmark not defined.
   7.2 Board and Committee Responsibilities .......................................................................... Error! Bookmark not defined.
   7.2.1 Trust Board .................................................................................................................. Error! Bookmark not defined.
   7.2.2 Governance and Risk Committee ............................................................................. Error! Bookmark not defined.
   7.2.3 All Trust Committees ................................................................................................. Error! Bookmark not defined.
8 Training Requirements .......................................................................................................... Error! Bookmark not defined.
9 Monitoring and Compliance ................................................................................................. Error! Bookmark not defined.
10 References and Related Documentation .............................................................................. Error! Bookmark not defined.
11 Attachments ........................................................................................................................ Error! Bookmark not defined.
Meta Data

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<thead>
<tr>
<th>Document Title:</th>
<th>Policy for the Insertion and Management ofPeripheral Venous Cannula (PVC)</th>
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<tbody>
<tr>
<td>Status</td>
<td>Approved</td>
</tr>
<tr>
<td>Document Author:</td>
<td>Rachael Priddle – Senior Faculty Educator -IV, V&amp;C Lead Alice Demuth –Infection Control Nurse</td>
</tr>
<tr>
<td>Source Directorate:</td>
<td>Infection Prevention Team</td>
</tr>
<tr>
<td>Date Of Release:</td>
<td>May 2011</td>
</tr>
<tr>
<td>Ratification Date:</td>
<td>26.5.2011</td>
</tr>
<tr>
<td>Ratified by:</td>
<td>TIPC</td>
</tr>
<tr>
<td>Review Date:</td>
<td>November 2011</td>
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| Related documents | • Infection Control Policy  
• Waste Policy  
• Sharps Policy  
• Hand Decontamination Policy  
• Standard Precautions Policy  
• 6 Golden Rules  
• Aseptic Non Touch Technique Policy  
• Medicines Policy  
• SOP for Peripheral Venous Cannulation  
• SOP for Intravenous Therapy Administration  
• Nursing Guideline for Peripheral Venous Cannulation  
• Nursing Guideline for Intravenous Therapy Administration |
| Superseded documents | • Policy for the management of Peripheral Venous Catheters (PVC) in the Heart of England Foundation Trust v.1 |
| Relevant External Standards/ Legislation | • Care Quality Commission : The Health and Social Act 2008  
• NHS Litigation Authority  
• Department of Health document : Saving Lives |
| Key Words | Peripheral Venous Cannula, PVC, ANTT, Infection Control, VIP Scores |

Revision History

<table>
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<tr>
<th>Version</th>
<th>Status</th>
<th>Date</th>
<th>Consultee</th>
<th>Comments</th>
<th>Action from Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>approved</td>
<td>26.5.11</td>
<td>TIPC</td>
<td>6 month approval then review with Solihull community comments</td>
<td>circulate</td>
</tr>
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1  **Circulation**

1.1. This policy should be read by all staff responsible for the insertion, management and care of a peripheral venous cannula (PVC) in the clinical setting

1.2. This policy applies equally to staff in a permanent, temporary, voluntary or contractor role acting for or on behalf of HEFT.

2.  **Scope**

   This policy applies to all new and revised HEFT PVC Policies across all locations and services, including adults and children over the age of 2 months

**Excludes:**

- This policy does not cover the insertion, management and care of a Central Venous Catheter (CVC), Peripherally Inserted Central Venous Catheters (PICC) or Hickman line, „mid-line”, „long-line cannula.
- Neonates

3  **Definitions**

- PVC - Peripheral Venous Cannula
- ANTT – Aseptic Non Touch Technique
- Practitioner – medical staff, registered nurses, midwives, radiographers and other registered and non-registered authorised staff who have undergone HEFT Cannulation training or can prove equivalent competence by Accreditation of Prior Experience and Learning (APEL)
- VIP Score – Visual Infusion Phlebitis Score chart adapted from Andrew Jackson, Nurse Consultant and B Braun (Appendix1)
- Needle free device - an add on device which allows infusion connection, injection and changing of administration sets whilst maintains a closed IV system
- TPN – Total Parenteral Nutrition.
- IV - intravenous

4  **Reason for development**

The purpose of this policy is to

- Inform all practitioners of their responsibility in safe and effective peripheral venous cannulation
- Reduce the incidence of catheter related blood stream infections within Heart of England NHS Foundation Trust (HEFT).
- Outline National and Trust recommendations on the care and management of a PVC in the clinical setting, increasing standardisation of practice.
- Ensure all PVC are inserted by practitioners who have received the appropriate training, can demonstrate the appropriate knowledge, skill and competence in order to practice the skill without supervision (RCN 2010)
5 Aims and Objectives

Aim

- To ensure that practitioners involved in the insertion, ongoing care and removal of peripheral intravenous cannula carry out the procedure safely and correctly at all times

6 Standards for Policies

Introduction

A peripheral venous cannula (PVC) is a flexible hollow tube containing a needle (Stylet) that is placed in a venous blood vessel, usually into the veins of the hand or forearm and occasionally lower limbs of patients (only if competent to do so). (Mallett and Dougherty, 2005). The stylet is removed once the cannula is in position, enabling venous access for the administration of medications or fluids via this route.

PVC's are relatively easy to insert and allow a comfortable form of therapy for the patient. However they can present a high risk for infection because of the potential for direct microbial entry into the blood stream. PVC’s may be contaminated by the patients skin flora at insertion or by the introduction of organisms via the cannula hub or injection port.

The use of peripheral venous cannula and the administration of drugs and solutions can occasionally result in painful complications. However, correct technique, training, competence, appropriate standards of hygiene and a sound knowledge of the equipment can minimise their occurrences and severity.

Indication for Intravenous cannulation

Peripheral intravenous therapy is usually for short-term therapy (2-5 days) and used to administer continuous or intermittent intravenous infusions of fluids, bolus drugs, TPN, blood products or to maintain venous access. In all cases first consideration should be for the administration of therapy by alternative routes where possible and should encompass treatment suitability and patients” consultation. Inappropriate use of cannulation may lead to higher levels of infection and should be avoided where possible.

The usual indications are for:-

- Maintenance of fluid balance
- Correction of electrolytes
- Administration of intravenous medication.
- Resuscitation
- Haemodialysis
- Anaesthesia
- To assist diagnosis
• If the patient has a known history of medical complications e.g. Post partum haemorrhage, if a patient is deteriorating in A/E.

Contra-indications for Peripheral Venous Cannulation

• If the patient has not given informed consent, or if the patient is lacking in capacity – see HEFT Policy on Consent.
• In situations where due to lack of patient compliance the practitioner is put at risk.
• Below the site of a previous intravenous cannula.
• In areas of local sepsis.
• On a sleeping patient.
• On a limb where there is evidence of lymphoedema, or where surgery on axillary lymph nodes has taken place.
• In, above or below a renal fistula – unless qualified to do so
• On a patient on the palliative care pathway unless essential for the continuing care and comfort of the patient.
• Proceed with caution in the foot and leg. This is not advised as a first choice.
• Proceed with caution on an upper limb that is paralysed where no other access site available.
• Children and Neonates without adequate training and competence.

Consent

See HEFT Policy on Consent for Treatment

Selection of insertion site and contraindications

The preferred insertion site for PVC’s is the upper extremities of the body because veins are located just beneath the skin. Veins in the lower extremities should not be used routinely due to risk of embolism and thrombo-phlebitis (Dougherty 1999). Site selection should avoid areas of flexion although this may not always be possible in an emergency situation such as during resuscitation when the ante-cubital fossa is recommended.

Certain conditions e.g. haematological disorders restrict the practice of peripheral venous cannulation requiring referral to specialist services (Davies, 1998).

When selecting a suitable vein and site both the required cannula size (depending upon clinical need (see Appendix 2) and the site and state of available veins must be taken into consideration. Preferably the vein should also be unused, easily detected, patent and healthy. The choice of vein needs to be appropriate for the proposed use of the cannula necessitating knowledge of anatomy and physiology and selecting the smallest gauge cannula that will adequately deliver the desired therapy.

General rules for vein selection include:

• Avoid median cubital veins at the ante-cubital fossa (reserved for venous blood sampling).
• Distal veins should be used first with subsequent attempts proximal to previous sites.
• Always allowing time for inspection and palpation of the patient’s forearm and dorsum of hand to select site.
• In difficult cases, ensuring maximum venous dilation before inspection.
• If in doubt, consulting a more experienced colleague.
• Using veins on the patient’s non-dominant side if possible.
• Using opposite side for cannulation to any surgical procedure.

A good vein is:

• Soft
• Bouncy
• Refills when depressed
• Well supported
• Visible
• Straight

The following veins should be avoided:

• Small and visible but impalpable
• Irritated from previous use
• Tortuous/mobile
• Sclerosed / fibroed / thrombosed
• Inflamed
• Painful/sore/bruised
• Hard
• Thin/fragile
• Near bony prominences or areas of joint flexion
• Adjacent to foci of infection
• In the lower extremities (increased risk of thrombophlebitis and pulmonary emboli)
• Close to arteries or deeper lying vessels

Venous access may also be impaired by:

• Injury or disease
• Amputation, fracture or paralysed limb
• Impairment of lymphatic drainage (e.g. mastectomy)
• Positioning of the patient
• Oedematous limbs (these carry an increased risk of phlebitis and cellulitis)
• Obesity/malnourishment
• Operation on one side of the body

Additional factors affecting the choice of vein include:

• Age of the patient
• Previous uses and condition of the veins
• Clinical state of the patient i.e. dehydrated, shock, stroke, thrombocytopenia, mastectomy, dialysis fistula (exception shall be made for diagnosis purposes, e.g. fistulogram).
• Other clinical procedures required during admission
• Type and length of treatment
• Patient preference
• Medication i.e. warfarin, steroids
• Patient co-operation/previous experiences
• Pre-post operative sites

Subsequent cannulation should be made proximal to the previously cannulated site (Weinstein, 2000)

**Equipment required**

Staff must ensure that they are familiar with the equipment in use in their area of work and check equipment for expiry dates and visible signs of contamination. The Trust supplies a specific cannula to minimise risk of needle stick injury from the procedure. Any problems with cannulation equipment should be reported in accordance with the Trust’s incident reporting policy and procedures.

• Aseptic technique trolley
• Alcohol hand gel
• Apron
• Non sterile gloves
• Facial protection, if there is a risk of blood or bodily fluid splashes
• Cannulation pack- this contains a sterile transparent dressing, Chloroprep, sterile towel, gauze swabs and insertion label
• Disposable tourniquet
• PVC according to clinical requirements and age of patient
• Equipment required for flushing -10ml syringe, 0.9 % sodium chloride ampoule and a green needle
• Sharps bin
• Prescribed local anaesthetic cream if required

**Selection of appropriate PVC and equipment required**

In selecting a cannula the following must be taken into account:

• Size, state and blood flow of available veins, noting that a cannula must never totally occlude a vein.
• Cannula length should correspond approximately to the length of straight vein to be used in order to prevent mechanical irritation.
• Local anatomy/problems e.g. contractures etc, stroke
• Infusion rate required - high rates will require a large vein and cannula to ensure adequate blood flow
• Type of infusate - potent drug and/or irritant solutions will require a large blood flow around the cannula to assist haemodilution and prevent damage to the intima of the vein wall, therefore a smaller cannula is ideal.
• Expected duration of IV therapy.

NOTE:
• Always use the smallest size cannula possible to adequately deliver the desired intravenous fluids.
• A smaller cannula will permit a higher blood flow around the cannula thus improving the haemodilution of fluids and drugs administered.
• The degree of mechanical irritation and insertion trauma is minimised by the use of smaller gauge cannula.
• Twenty gauge or smaller cannulas should be used for most PVC’s.
• A minimum 20 gauge catheter is required for infusion of peripheral TPN.
• 1% lignocaine should be used via intradermal injection as a local anaesthetic prior to insertion for a cannula greater than 20 gauge.

Complications of Insertion and maintenance

Transfixation

Transfixion is the complication of the cannula accidentally piercing the lower vein layer leading to bleeding and risk of haematoma. Without careful checks post cannula insertion, infusion therapy may appear patent, but drugs can enter the vascular space causing probable extravasation or infiltration. If the vein appears transfixed, the cannula must be withdrawn and pressure applied to the site until coagulation.

Haematoma/haemorrhage.

This is a direct consequence of transfixation, whereby the vascular space fills up with blood and causes swelling in the arm or hand. If this occurs, withdraw the cannula immediately and apply pressure to the site.

Bruising

This is a consequence of haemorrhage and haematoma as the bleed subsides in the tissues. This can also be caused by keeping the tourniquet on the patient for longer than 2 minutes and also exacerbated by patients on certain coagulant or steroid medication.

Pain

This is the most common complication of inserting a PVC. Ensure that the patient can access topical anaesthetics prior to insertion, or 1% lignocaine injections if using a cannula greater than 20 gauge. Proper patient preparation can also aid pain reduction.

Vaso- vagal /anxiety attacks
Patients can be at risk of anxiety during the procedure. If the patient feels anxious ensure that you cannulate the patient on the bed to prevent the risk of falls and accidental needle stick injury.

**Mechanical Phlebitis**

Mechanical phlebitis is the term used when the cannula irritates the intima lining of the vessel, causing redness, heat and swelling of the vein. This is not infection, but can be identified as a VIP score +1. To reduce complications, careful monitoring is required by increased patient education to reduce movement and friction from lines and to reduce manipulation and trauma from line and dressing changes. Secure the cannula with a well fitting dressing, ensure extension sets are not too heavy and provide analgesia for the patient.

**Infiltration**

Infiltration if the term commonly referred to as “tissuing”. It is the inadvertent administration of a non-vesicant solution e.g. 0.9% sodium chloride into the surrounding tissues causing swelling and pain. This can be caused by transfixation of the cannula, poor monitoring or simple cannula dislodgement. Early recognition is vital for treatment to commence as the infusion can appear patent.

**Chemical Phlebitis**

Chemical phlebitis is the term used to describe a side effect of infusion therapy of substances with a high or low pH value. These substances can highly irritate the vein wall, and increase redness and swelling along the vein. This is commonly referred to as „tracking“. The solution is to ensure that flow rates are regulated and all therapy is infused through a mechanical device. Even though the VIP score may indicate +1, careful assessment and future monitoring may be required as reducing the flow rate and increasing the dilution of the substance can reduce the redness and trauma. Choosing the correct cannula size and alternate cannula positions will see the vein return to normal.

**Extravasation**

Extravasation is the term used when a vesicant substance, such as potassium chloride or glucose is inadvertently administered into the surrounding tissues causing pain, swelling and a resulting necrosis of the tissues. This can lead to subsequent infection and permanent tissue damage. This can be caused by transfixation, cannula dislodgement and poor monitoring. Early recognition is vital, as early treatments require medical assistance as soon as possible.

**Infection (Local and systemic)***

Intravenous catheter-related infections are systemic infections which have a vascular access device (VAD) catheter as the source. Every year in the UK an estimated 6,000 patients develop a catheter-related bloodstream infection (CR-BSI) (Elliot, 2001). The infections are associated with a high morbidity and mortality, particularly in hospitalised
patients.

Catheter Related Blood Stream Infection’s (CRB-SI’s) are caused by micro-organisms, such as Staphylococcus aureus and Staphylococcus epidermis. These organisms found on the patient’s skin contaminate the catheter during insertion, or migrate along the catheter track. Contaminated fluids and equipment, cross infection and colonised hands are also factors implicated in catheter related infection.

- Do not insert a PVC unless it is clinically indicated
- Non touch aseptic technique and standard precautions must be adhered to during PVC insertion and all intravenous procedures
- Do not touch key parts –

**Example of Key Parts**

**Key Parts** are defined as those parts or sites that if contaminated with micro-organisms increase the risk of infection.

This diagram highlights those parts in red
- PVC must be observed for signs of phlebitis at least 8 hourly using the VIP score and take appropriate action depending on findings, document scores on PVC charts.

- Standardised cannulation packs and a dressing trolley must be used at all times when inserting a PVC, with the exception being an emergency situation.
- Only one PVC device will be used for each cannulation attempt.
- PVC’s inserted during an emergency situation where aseptic technique was compromised must be removed within 24 hours or as soon as possible

**Local Infection**

Local infection is determined by a Visual Infusion Phlebitis (VIP) score of 2 or more, or clinical indications of local redness, swelling and heat. This usually determines the presence of the early stages infection that has not reached systemic proportions. The usual action is to remove the cannula, assess whether another is required and contact medical assistance for advice.

**Systemic Infection**

Systemic infection is the direct result of a bacterium entering the blood stream of a cannula following poor asepsis procedure of insertion and maintenance of a cannula. This can directly contribute to septicemia of the patient, which can prove fatal if not identified and treated effectively. Systemic infection is determined by the presence of a VIP score of 2 or more, raised pulse, variances in blood pressure and cold and clammy appearance. Seek medical assistance immediately. Systemic infection can be life threatening if not treated immediately.
Preventing infection on insertion

**Tourniquets:** A disposable tourniquet must be used. Do not use a latex glove.

**Hand Hygiene:** Wash hands with liquid soap and water followed by alcohol hand rub before insertion. (See [HEFT Hand Hygiene policy](#)).

**Technique:** Aseptic non touch technique (see [HEFT Aseptic Non-Touch Technique Policy](#)).

**Skin preparation:** Prior to PVC insertion the skin must be prepared with 2% chlorhexidine gluconate/70% isopropyl alcohol applicator (Chloraprep) and then leave to dry for 30 seconds. Shaving of the skin should be avoided. If hair removal is required hair should be clipped using a disposable clipper head. before the insertion of the cannula (Dougherty, 1999). DO NOT REPALPATE THE VEIN ONCE THE SKIN HAS BEEN CLEANED. If this is unavoidable, then the area must be cleaned again.

**Chloroprep is not licensed to be used on children under 2 months of age**

**Insertion of PVC:** See Standard Operational Procedure for insertion of PVC.

**Dressing required:** Secure the cannula in position using a transparent, semi - permeable polyurethane peripheral cannula dressing. The date and time of insertion should be recorded on the cannula dressing.

The purpose of the dressing is to:

a. **Protect the puncture site and minimise the possibility of infection via the interface between the catheter surface and the skin.**

   The cannula insertion site is an open wound. The dressing must be sterile and applied under aseptic conditions. An appropriate transparent or semi-occlusive intravenous cannulation dressing must be used taking into account any patient allergies.

b. **Allow observation of the insertion site.**

   Easy visual inspection without removal of the dressing allows early detection of inflammation, extravasation and collection of blood or pus at the insertion site. It also allows careful observation during the injection of drugs. This assists with keeping infection to a minimum.

c. **Secure the device in place and prevent movement of the device which damages the vessel.**

   The dressing should conform well to the area of the intravenous site and allow freedom of movement and be well tolerated. When in place, the dressing should be secure enough to prevent the line dislodging, cannula movement, which could introduce bacteria and drugs into the intravascular space leading to extravasation, mechanical irritation and infection.

   The dressing should be easy to remove without dislodging the cannula and without leaving residual adhesive on the skin.
NOTE:

- To reduce the risk of infection, any soiled, wet, loose or dirty dressing must always be changed as soon as possible. Label changed dressings with the original date and time of PVC insertion.
- The fewer the dressing changes, the lower the risk of introducing bacteria to the puncture site, with the exception of patients developing problems at the site that require further inspection.
- The dressing should remain in place for up to 72 hours, after this time the cannula should be re-sited.

chloroprep must not be used on children under 2 months of age.
**Patency Maintenance**

**Flushing of PVC and patency maintenance**

Once the PVC is in place the catheter shall be flushed with 5mls 0.9% Sodium Chloride in a 10ml syringe.

**Flushing technique:** A pulsated push-pause and positive pressure method should be used. Positive pressure with the lumen of the catheter should be maintained to prevent reflux. (RCN 2010).

**Flushing PVC in IV drug administration:** Flushing with 0.9% sodium chloride solution, to ensure and maintain patency, shall be performed before, between and after the administration of all intravenous medications and/or solutions. The minimal volume of 0.9% sodium chloride shall be 5mls.

All 0.9% sodium chloride solution flushes shall be prescribed or used as a PGD

**Manipulation of the PVC system**

Keep manipulation to an absolute minimum in order to minimize the risk of contamination.

**Prior to cannula use**

- Decontaminate hands, and apply gloves and apron
- Check date and time of dressing
- Check VIP score
- Clean hub with 2% chlorhexidine gluconate in 70% alcohol swab in order to disinfect the PVC hub or needle free device prior to administration of fluids or medication. The hub should be cleaned for 30 seconds and allow to air dry.

**Documentation**

Complete insertion details on the RED PVC sticker and apply to phlebitis chart

Document in the patients' notes:-

- Date and time device inserted
- Insertion site
- Name of person inserting device
- Consider documentation of product number and gauge for traceability.

All patients with a peripheral cannula in situ must also have a peripheral core care plan which must be evaluated and documented per shift
Site assessment of complications post insertion

The cannula and surrounding sites should be assessed every 8 hours for signs of complications such as pain, redness, swelling, indurations or disruption of flow (RCN 2010). The VIP score should be documented and whether actions are taken.

Patients shall be encouraged to report any changes in their PVC site or any new discomfort to medical staff. Ensure patient or relative has been given the patient leaflet titled “Peripheral cannula”. This can accessed in the infection control web page.

Administration of Fluids

Except in the operating room and in emergency situations, all PVC fluids, where possible, shall be administered by infusion pump. Patients who are receiving fluids with potassium or patients who have known cardiac disease should always have fluids administered via an infusion pump.

Peripheral TPN should be administered through a designated PVC with no additional fluids via an infusion pump.

Line care

- Clamps should be applied to lumens/lines when not in use to prevent backtracking.
- Administration sets must be labelled with the set up date and time
- All PVC administration set tubing shall be primed and inspected for the presence of air, which should be eliminated before use.

Frequency of change of administration sets

The type of solution administered via an administration set should dictate whether the administration set is changed more frequently than 72 hours

- Administration sets must be labelled with the set up date and time
- For total parental nutrition the administration set should be changed using an aseptic technique using sterile gloves every 24 hours
- Blood transfusion administration sets, shall be changed after the infusion of 2 units of blood or after 12 hours whichever sooner or prior to a platelet infusion.
- Drugs that have the potential to be absorbed by the administration set such as insulin should be changed every 24 hours
Needle-free device

Needle free devices should be used on all PVC where frequent manipulation or disconnection is anticipated. Single, double and triple lumen needle free devices are available for patients on multiple infusions, or intermittent infusions.

- Careful consideration must be given when selecting a suitable needle free device as safety mechanism and flow rates between brands and ranges vary. i.e. anti-reflux valves, non return valves.
- Replace needle-free device when PVC is re-sited
- Keep add on devices to a minimum

Disconnection of administration sets

- If the administration set or any tubing attached becomes disconnected then discard and attach a new infusion set.
- Intermittent infusion sets if disconnected from the patient must be discarded and NOT capped off for further use
- All giving sets that have had drugs administered via them must be disposed of in sharps containers.

Removal of PVC - Indications for removal or replacement

- Remove PVC using ANTT if VIP score is 2 or above and assess need to replace. (NB. Following a risk assessment it may be necessary to insert the new cannula before removing the original).
- When a new PVC is re-sited a new administration set, needle free device and fluid infusion must be used.
- If the assessment determines that the cannula is not to be re-sited then this must be documented.
- Continue to observe insertion site if PVC is removed due to phlebitis/infection and act upon findings.
- If a localised infection is suspected at the PVC insertion site, medical staff must be informed.
- Remove PVC as soon as it is not required or replace every 72 hours or sooner if clinically indicated. The decision to leave a PVC in place longer than 72 hours must be documented in the patient’s medical notes and VIP score increased
- Document PVC removal on phlebitis chart
- PVC’s inserted under non-sterile conditions during an emergency shall be removed and re-sited within 24 hours.
7 Responsibilities

Individual Responsibilities

Trust Management are responsible for:

- The Chief Executive has overall responsibility for the implementation, monitoring and renewal of this policy

Group Operational Leads are responsible for:

- Group Operational Leads Teams are responsible for overseeing all aspects of risk management including financial, organisational and clinical within each of their local areas. They should ensure all aspects of the PVC policy are implemented by their teams
- The additional funding and resources necessary to manage PVC care safely and effectively

Clinical teams are responsible for:

- Ensuring that their staff have received appropriate training for insertion, removal and ongoing care of peripheral venous catheter
- Only inserting PVC’s when clinically indicated using a non touch technique
- Document PVC insertion details using the red sticker available in the cannulation packs
- The prompt and timely removal of PVC’s
- Treating infected PVC sites appropriately and promptly according to the Trust’s antibiotic guidelines
- Liaising with the microbiology Team to ensure patient who are slow to respond to treatment are reviewed and treatment changed accordingly
- Adhering to infection control policies

The Infection Control Team are responsible for:

- Developing and reviewing the PVC policy in conjunction with the faculty of education
- Developing an audit programme to observe compliance with the PVC care policy
- Providing education to clinical staff on the signs and symptoms of phlebitis and the early detection of possible peripheral cannula related infections using the VIP score
• Providing training and education on peripheral cannula care in conjunction with the faculty of education peripheral cannulation training and stand alone infection training sessions ward based

• Communicating up to date information relating to peripheral venous catheters to appropriate personal within the Trust i.e. the standard operating groups

**Managers/Senior Sisters/Nurse in Charge are responsible for:**

• Ensure dissemination of this policy

• Enforce this policy in their area

• Ensure appropriate equipment is available to undertake all aspects of insertion, ongoing care and removal

• Facilitate the delivery of education provided by the infection control team.

• Ensure all staff on their ward who are involved in the insertion, ongoing care and removal of PVC have received the appropriate training from the Faculty of Education’s PVC and IV course.

• Ensure that a record of competency is maintained and recorded on the staff members personal file. Any further educational needs are identified at appraisal

• Monitoring for signs of infection using the VIP score at least 8 hourly, document findings on the VIP chart, and take appropriate action depending on findings

• Ensure that any temporary staff are competent to undertake insertion, ongoing care and removal of PVC

• The prompt and timely removal of PVC’s

**All Staff are responsible for:**

• All practitioners have responsibility and accountability for their own development; Registered nurses are required to demonstrate that they possess the knowledge, skills and abilities required for lawful, safe and effective practice without direct supervision NMC

• Adhering to the Trust’s Infection Prevention and Control Standard policies

• Challenging the poor practice of others

• Promptly reporting patients with symptoms of an infection to the medical staff
• Health care Assistants, Student Nurses and other allied Health care professions should only undertake PVC removal procedure once deemed appropriate for their duties and have been assessed as competent to perform.

Board and Committee Responsibilities

Ratifying Board and Committee Responsibilities

• The purpose of the Trust Infection Prevention Committee is to ensure continuous improvement and reduction in rates of healthcare associated infection while proving a Trust wide operations facilitation forum for control of infection. The group consists of a membership including Management, Nursing, Infection Control and Hotel Services.

8 Training Requirements

• Nurses, midwives and radiographers MUST be competent in the administration of intravenous drugs (In accordance with the Trust administration of intravenous drugs policy ), prior to carrying out PVC.

• Other non-registered practitioners MUST NOT administer 0.9% sodium chloride flush post-cannula insertion UNLESS they have SPECIFICALLY COMPLETED the approved Trust training in accordance with the relevant Trust policy or NVQ unit

• Other non-registered practitioners MUST NOT carry out PVC on paediatric patients (i.e. 16 years or younger)

• Other non-registered authorised staff must only carry out PVC for a named patient on the verbal or written instructions of a Doctor, nurse or radiographer. Other staff CANNOT give such authorisation.

• All newly appointed registered nurses, midwives and radiographers may provide evidence of previous education and training by:-

  • Providing written evidence from a previous hospital
  • Demonstrating practical and theoretical competence using HEFT Cannulation Competence as APEL.

• Otherwise, Trust Cannulation training MUST be undertaken prior to a period of supervised practice and completion of the Trust Cannulation Competence.

• Medical staff must be assessed as competent in non touch aseptic technique on induction

9 Monitoring and Compliance
• Aspects related to the insertion of PVCs and associated care will be audited to assess compliance with the PVC policy as indicated in the infection prevention and control annual program using the Department of Health Saving lives audit tool.

• Any untoward incidents and complaints

10 Attachments

Add attachments starting a new page for each attachment

The following attachments must be included:

Attachment 1: Consultation and Ratification
Attachment 2: Equality Impact Assessment (EIA)
Attachment 3: Launch and Implementation Plan
Attachment 4: References and Associated Documentation
## Attachment 1: Ratification Checklist

<table>
<thead>
<tr>
<th>Ratification checklist</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Is this a: Combined Policy &amp; Procedure</td>
<td>Yes</td>
</tr>
<tr>
<td>2 Is this: Revised</td>
<td>Yes</td>
</tr>
<tr>
<td>3* Format matches Policies and Procedures Template (Organisation-wide)</td>
<td>Yes</td>
</tr>
<tr>
<td>4* Consultation with range of internal /external groups/ individuals</td>
<td>Faculty of Education Infection Prevention Team TIPC</td>
</tr>
<tr>
<td>5* Equality Impact Assessment completed</td>
<td>Yes</td>
</tr>
<tr>
<td>6 Are there any governance or risk implications? (e.g. patient safety, clinical effectiveness, compliance with or deviation from National guidance or legislation etc)</td>
<td>Yes</td>
</tr>
<tr>
<td>7 Are there any operational implications?</td>
<td>Yes TIPC</td>
</tr>
<tr>
<td>8 Are there any educational or training implications?</td>
<td>Yes Ongoing training programme for nurses, midwives and radiographers must continue</td>
</tr>
<tr>
<td>9 Are there any clinical implications?</td>
<td>Yes TIPC</td>
</tr>
<tr>
<td>10 Are there any nursing implications?</td>
<td>Yes TIPC</td>
</tr>
<tr>
<td>11 Does the document have financial implications?</td>
<td>No</td>
</tr>
<tr>
<td>12 Does the document have HR implications?</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Question</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>13*</td>
<td>Is there a launch/communication/implementation plan within the document?</td>
</tr>
<tr>
<td>14*</td>
<td>Is there a monitoring plan within the document?</td>
</tr>
<tr>
<td>15*</td>
<td>Does the document have a review date in line with the Policies and Procedures Framework?</td>
</tr>
<tr>
<td>16*</td>
<td>Is there a named Director responsible for review of the document?</td>
</tr>
<tr>
<td>17*</td>
<td>Is there a named committee with clearly stated responsibility for approval monitoring and review of the document?</td>
</tr>
</tbody>
</table>

Document Author / Sponsor

Signed ................................................

Title..........................................................

Date..........................................................

**Ratified** by (Chair of Trust Committee or Executive Lead)

Signed ................................................

Title..........................................................

Date..........................................................
Attachment 2: Equality and Diversity - Policy Screening Checklist

<table>
<thead>
<tr>
<th>Policy/Service Title: Policy and Procedures HEFT framework</th>
<th>Directorate: laboratory medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of person/s auditing/developing/authoring a policy/service: Rachael Priddle</td>
<td></td>
</tr>
<tr>
<td>Aims/Objectives of policy/service: to define a systematic approach and required standards for the development, ratification, implementation, monitoring, review and retirement of Policies for PVC and associated Procedures.</td>
<td></td>
</tr>
</tbody>
</table>

**Policy Content:**

- For each of the following check the policy/service is sensitive to people of different age, ethnicity, gender, disability, religion or belief, and sexual orientation?
- The checklists below will help you to see any strengths and/or highlight improvements required to ensure that the policy/service is compliant with equality legislation.

### 1. Check for DIRECT discrimination against any group of SERVICE USERS:

<table>
<thead>
<tr>
<th>Question:</th>
<th>Response</th>
<th>Action required</th>
<th>Resource implication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your policy/service contain any statements/functions which may exclude people from using the services who otherwise meet the criteria under the grounds of:</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>1.1 Age?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 Gender (Male, Female and Transsexual)?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 Disability?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.4 Race or Ethnicity?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.5 Religious, Spiritual belief (including other belief)?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.6 Sexual Orientation?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

### 2. Check for INDIRECT discrimination against any group of SERVICE USERS:

<table>
<thead>
<tr>
<th>Question:</th>
<th>Response</th>
<th>Action required</th>
<th>Resource implication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your policy/service contain any statements/functions which may exclude employees from operating the under the grounds of:</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>2.1 Age?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2 Gender (Male, Female and Transsexual)?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3 Disability?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4 Race or Ethnicity?</td>
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<td></td>
</tr>
<tr>
<td>2.5 Religious, Spiritual belief (including other belief)?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.6 Sexual Orientation?</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2.7 Human Rights: Freedom of Information/Data Protection  

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

**TOTAL NUMBER OF ITEMS ANSWERED ‘YES’ INDICATING DIRECT DISCRIMINATION =**

### 3. Check for DIRECT discrimination against any group relating to EMPLOYEES:

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Action required</th>
<th>Resource implication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>3.1 Age?</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3.2 Gender (Male, Female and Transsexual)?</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3.3 Disability?</td>
<td></td>
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<td>3.5 Religious, Spiritual belief (including other belief)?</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3.6 Sexual Orientation?</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

### 4. Check for INDIRECT discrimination against any group relating to EMPLOYEES:

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Action required</th>
<th>Resource implication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>4.1 Age?</td>
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<td>X</td>
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<tr>
<td>4.2 Gender (Male, Female and Transsexual)?</td>
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<td>4.5 Religious, Spiritual belief (including other belief)?</td>
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<td></td>
</tr>
<tr>
<td>4.6 Sexual Orientation?</td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

If yes is answered to any of the above items the policy/service may be considered discriminatory and requires review and further work to ensure compliance with legislation.

**TOTAL NUMBER OF ITEMS ANSWERED ‘YES’ INDICATING INDIRECT DISCRIMINATION = 0**
Attachment 3: Launch and Implementation Plan
To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

<table>
<thead>
<tr>
<th>Action</th>
<th>Who</th>
<th>When</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify key users / policy writers</td>
<td>IPCT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Present Policy to key user groups</td>
<td>Circulate to Solihull community users</td>
<td>immediate</td>
<td>Via IPCT</td>
</tr>
<tr>
<td>Offer awareness training / incorporate within existing training programmes</td>
<td>Faculty of education</td>
<td>ongoing</td>
<td></td>
</tr>
<tr>
<td>Circulation of document(electronic)</td>
<td>IPCT</td>
<td>May 2011</td>
<td></td>
</tr>
</tbody>
</table>
References

COSH Policy (2008)


Elliot (2001) Guidelines for preventing catheter related infections, published by the infection control nurses in collaboration with 3M


HEFT Aseptic Non Touch Technique Policy (2008)


HEFT Consent for Treatment Policy (2008)

HEFT Medical Devices Policy (2008)
HEFT Medicines Code (2008)
HEFT Positive Identification of Patients Policy (2009)
HEFT Peripheral Venous Cannulation Policy (2007)
HEFT Record Keeping Policy (2009)
HEFT Uniform Policy (2009)


NICE Guidance (2006)


Standards for medicine administration. NMC (2008) www.nmc-org.uk

Standards to support learning and assessment in Practice NMC (2008) NMC www.nmc-org.uk

The Code: (Standards of Conduct, Performance and Ethics for Nurses and Midwives) NMC (2008) www.nmc-org.uk
