Birmingham Children's Hospital NHS
NHS Foundation Trust

Policy for the Care and Management of Ports

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Contents

Appendices

Appendix A Guidelines for the use of Micro-Claves

Appendix B Management of Blocked Central Venous Catheters

Appendix C Recommended ANTT for commonly performed procedures

Appendix D CVL Insertion, Access and On-going Care audit forms

1 Introduction

This policy was developed to ensure that there consistency in practice when for caring for infants, children and young people with ports.

2 Purpose

2.1 To inform staff of their responsibilities regarding the care and management of ports.

2.2 To provide a concise theoretical framework based on accepted evidence based practice.

2.3 To ensure practice is consistent throughout the Trust.

3 Duties

3.1. All qualified staff are responsible for ensuring their practice complies within this policy.

3.2 It is the responsibility of the local manager to ensure that the policy and its procedures are made available to all staff.

3.3 This Trust policy will support the training, competency based assessment and clinical practice in the working environment.

3.4 All staff must ensure that they comply with the requirements for Aseptic Non-Touch Technique.

3.5 All staff are responsible for monitoring and maintaining standards of care via monthly audit of High Impact Interventions for insertion; access and on-going care of ports (Appendix G).

4 Method for development

4.1 This Policy applies to all clinical staff within the Trust and is to be used in all in and out patient areas.

4.2 A copy of the Care and Management of Ports policy must be available on the intranet for staff to read and refer to as necessary.

4.3 All clinical staff should be instructed on the location of the policy as part of their local induction programme and appropriate training given where necessary

4.4 Competency must be assessed for all staff using the Trust competency documents.

Policy developed in conjunction with the following professionals:

Clinical Nurse Specialist for Nutrition Support and Intestinal Failure Team, Clinical Education Team, Senior Nurse for Infection Control, Head of Anaesthetics and Clinical Lead Nurse PICU, Educational Lead from Oncology/Haematology, Cystic Fibrosis Clinical Nurse Specialist and Lead Cancer Pharmacist, Heads of Nursing, Operational Lead Nurses, PICU Registrar.

5 Content

5.1 Definition

A Port is a central venous access device which is completely implanted and attached to an indwelling catheter to ensure reliable vascular access for long term therapy. The proximal end of the catheter is tunnelled subcutaneously and connected to the Port. The distal end of the catheter is introduced into a central vein.

5.2 Booking a port insertion.

5.2.1 Elective Bookings (Insertions and Removals)

Requests must be made via the Vascular Access Service via the P drive on the Trust intranet. Bookings are assessed and scheduled accordingly by The Vascular Access Team; there will be organisational secretarial support. A password protected list of children waiting and scheduled for port insertion and removal is available on the Trust intranet.

Infection status of the patient must be checked at time of line booking and any patient infected or with a history of colonisation must be isolated on admission (if not already admitted); placed last on the list, and this must be recorded on the central booking form . If required the Infection Prevention and Control team can be contacted for advice on x 9966.

Particularly complicated cases merit further discussion with members of the vascular access service.

5.2.2 Urgent cases

These cases should be discussed initially with members of the Vascular Access Service on weekdays between 9am and 5pm or via the on-call Consultant Anaesthetist. This discussion must be conducted on a consultant to consultant basis to allow appropriate scheduling and the correct choice of line. The referring team may then book the child with the theatre co-ordinator, ext. 9562. A separate booking form is required for the emergency list. Such cases will not be booked without the discussion as described above and a CVC booking form completed.
Most lines are screened with X-ray or ultrasound and a radiographer.
The person booking the line should book the radiographer.
Details of microbiology issues and isolation status must be flagged up when booking the case.

5.2.3 Paediatric Intensive care Unit (PICU)

For patients on PICU needing a tunnelled CVC who do not need additional elective or emergency surgery, discussion with the Vascular Access Service and booking form completion are required. Patients on PICU who require a tunnelled CVC placed as part of the surgical process do not require booking.

5.2.4 Documentation

The indication, consent, procedure, line type and post-operative instructions must be documented in the patient health care record for each line placed. The positive confirmation of position and 'ready to use' status must be documented by the responsible practitioner placing the line on the BCH Care and Management of Central Venous Lines document (2016) (7).

5.3 Preparation of the patient

It is imperative that every line insertion is conducted according to the criteria identified in the High Impact Intervention Care Bundle for Central Venous Catheters (Appendix G). These criteria are incorporated in to the audit document for CVL Insertion.
All precautions must be taken as specified at all times and none are regarded as optional

5.3.1 Consent

Informed consent must be taken prior to the procedure following the BCH Consent to Treatment Trust Policy (Trust Intranet).

Physical, emotional and psychological preparation of both the child/young person and family prior to the insertion of the catheter is required. A play specialist and/or a child psychologist's involvement in preparation may be beneficial if any needle phobic or other anxieties are expressed.

The clinical indications, procedure technique, management and care of the port, the risks, complications and the length that the device is in situ need to be explained and discussed with either/both the child and family.

Written information should be provided in the format of a Central Line information booklet (8), 'Ben and Jigsaw' (9).

5.3.2 MSSA/MRSA

All patients undergoing CVC insertion must have a nose swab collected, which is tested for MSSA as well as MRSA as per Trust Policy for the prevention and clinical management of bloodstream infections with methicillin-sensitive Staphylococcus aureus (MSSA). Please state pre CVC insertion on microbiology form.

5.3.3 Pre-surgical washing pre-procedure

All patients (except cardiac) must be washed top-to-toe including hair with Octenisan undiluted, allowing a contact time of at least one minute prior to washing off. (2)
Cardiac patients must be washed top-to-toe including hair with 4% chlorhexidine scrub diluted 1:8, allowing a contact time of at least 1 minute prior to washing off as per infection control guidance.

5.4 Insertion

It is imperative that every port insertion is conducted according to the criteria identified in the High Impact Intervention Care Bundle (Appendix F). These criteria are incorporated in to the audit document for CVL Insertion.

All precautions must be taken as specified at all times. None are regarded as optional.

5.4.1. Skin Preparation prior to insertion

Prior to line insertion a 2% chlorhexidine 70% isopropyl alcohol solution (ChloraPrep) device must be used and allowed to dry, unless the patient is sensitive to chlorhexidine.

Chloraprep is not licenced in neonates < 2 months of age/< 1kg in weight/<26 weeks gestation due to fragility of the skin, and the risk of pooling of the product that can result in burns to the skin. Risks versus benefits must be weighed up carefully in this cohort of patients and a very gentle technique of application must be adopted, and the product be allowed to dry.

5.5 Port Access

Ideally the port should not be accessed for one week to allow the swelling to reduce and the site to heal. If immediate venous access is required the needle should inserted in theatre.
Prior to access the port should be palpated to ensure correct position.

5.5.1 Aseptic Non-Touch Technique (ANTT)

When inserting the needle or accessing the hub a standard Aseptic Non Touch Technique (ANTT) procedure must be used (Appendix C).
Infection, Prevention and Control Aseptic Non Touch Technique Policy (January 2017)

5.5.2 Topical anaesthetic

Topical anaesthetic should be prescribed and used wherever possible.

5.5.3 Site decontamination

Prior to needle insertion the site should be cleaned with a 2% chlorhexidine in 70% isopropyl alcohol solution (ChloraPrep) using a back and forth motion creating friction for at least 15 seconds and **be allowed to dry** (1). The needle site is a key part and must not be touched after cleaning.

5.5.4 Needles

There are varying lengths of needles used to access ports. This should be assessed on an individual patient basis and documented in the patient's health care record.

The needle primed with normal saline prior to insertion. The port should be held securely and the needle inserted at 90 ˚.

22 gauge non coring (Huber) needles must be used to access the port.

20 gauge needles are required for administration of blood products.

It is not routine practice to administer parenteral nutrition via a port due to the risk of extravasation.

5.5.5 Dressing

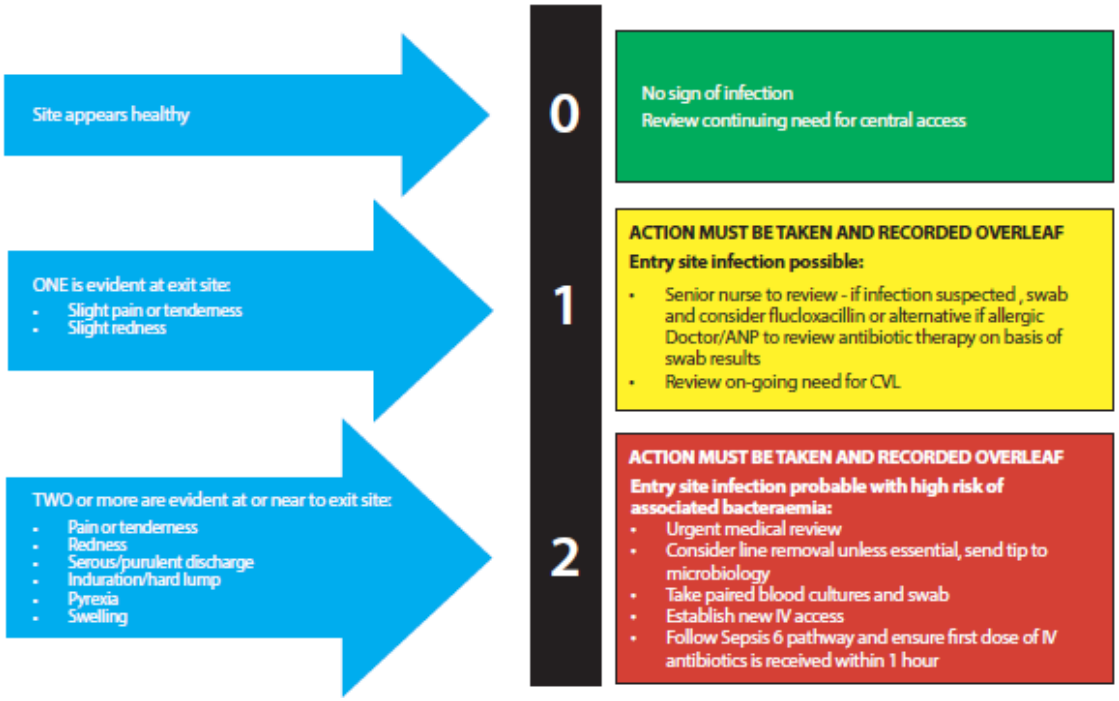
The needle should be secured with a using a sterile, transparent, semi-permeable dressing to allow observation of the site. More frequent dressing changes will be required should it become loose, soiled, wet or non-adhesive. IV 3000 is the current standard dressing as this allows for maximum evaporation of moisture.

The needle should be changed after 2 weeks of continuous therapy. For immunosuppressed patients this should be changed after 1 week.
The infusion lines should be fixed and supported in such a way that minimises the risk of pulling and accidental removal. See BCH Care and Management of Central Venous lines document (2016) (7).

5.6 On-going Care

5.6.1 Needle site observation

Site inspection is paramount in allowing prompt detection of complications.
A central line visual inspection site score must be carried out once every 12 hours and actions taken accordingly, and documented in the BCH Care and Management of Central Venous lines document (2016) (7).



5.6.2. Needle-free safety devices

Where needle-free devices are used the user must follow the manufacturer's instructions.
Micro clave guideline (Appendix A)

5.6.3 Syringes

10 ml syringes must be used when flushing a port or checking patency; as they exert less pressure and therefore can prevent damage to the catheter (2).

Smaller syringes may be required when administering accurate small doses or when cytotoxic medication is pre prepared in 2ml syringes. In such cases patency should be established with a 10 ml syringe initially.

Luer-lock syringes must be used where the medication is to be infused via an infusion pump.

5.6.4. Flushes/Maintaining patency

The catheter hub must be scrubbed for a minimum of 15 seconds with 2% chlorhexidine in 70% isopropyl alcohol solution **and allowed to dry** (1).

Prior to flushing the port must be aspirated to ensure patency and correct placement (2).
Flushing should be done using a push pause technique and the line clamped while positive pressure is maintained (2). If any therapies (drugs, fluids and bloods) are administered 0.9% normal saline should be used to flush the port in between them to prevent mixing.
Ports need to be flushed at least monthly to maintain patency.

The volume of flush should be equal to at least twice the volume of the catheter and add on devices (2)
Normal saline (0.9%) is sufficient if the catheter is being accessed less than 12 hourly (2).

If the catheter is being used less frequently than 12 hourly then the following should be administered.

2mls of Heparin 100units/ml (Ages 1-8 years)

4mls of Heparin 100units/ml (Ages 8 years and over)

The dose may vary dependent upon the priming volume of the catheter and/or size of the child.

5.6.5. Administration sets

Administration sets should be changed every 96 hours or immediately if contamination is suspected and this should be documented on the nursing care record (2).

Pharmaceutical guidelines may indicate more frequent changes due to stability of medication

Blood product administration lines should be changed when a transfusion episode is complete or every 12 hours (2).

Patient controlled analgesia should be infused using an anti-syphon administration set.

5.7 Complications

5.7.1 Infection

The incidence of Catheter Related Blood Stream Infection (CRBSI) varies considerably depending on the type of catheter, site of insertion, aseptic precautions undertaken, type of use and duration of insertion (10)

If either a local infection or a CRBSI is suspected, urgent treatment is required and the sepsis 6 BCH guideline must be followed which is available on the Trust intranet. The invasive device should be removed wherever possible; blood culture samples and needle site swab taken and appropriate treatment commenced. Any suspected infections, actions taken and reasons why the device could not be removed must be documented in the BCH Care and Management of Central Venous lines document (2016).
Practitioners should refer to local speciality guidelines or to a Consultant Microbiologist for guidance on treatment of a CRBSI.

5.7.2 Phlebitis, Infiltration and Extravasation

5.7.2.1 Definitions

Phlebitis is the inflammation of the vein and there are three types: bacterial, mechanical and chemical. Clinical signs of phlebitis include erythema, pain and warmth (3)

Infiltration is the inadvertent infusion of a non-vesicant medication into the surrounding tissue instead of the vein (3)

Extravasation is the inadvertent of a vesicant medication into the surrounding tissue instead of the vein (3)

5.7.2.2 Treatment

Refer to BCH Prevention of Extravasation Policy for recognition, treatment and management
During use the site should be monitored hourly to detect complications when not in use as per BCH Extravasation policy.

5.7.3 Air Embolus

Air embolus is defined as air in the vascular system and may reduce cardiac output and can prove fatal (5). The risk of air emboli is very real when caring for patients with central access devices, but can occur with any intravenous access. Air embolus can cause a fall in cardiac output and death.
Signs of air emboli include confusion, disorientation, cyanosis, hypotension, weak thready pulse or collapse. If suspected seek medical assistance immediately, turn the patient onto their left side and place in the Trendelenberg (head down) position and administer oxygen (6).

5.7.4 Occlusion/Failure to aspirate blood/persistent withdrawal occlusion

If it is not possible to aspirate blood from the port, this may indicate catheter occlusion. This could be related to the infusate, kinking or compression of the catheter, fibrin sheath formation or thrombosis.

Use the Management of Occluded Central Venous Catheters algorithm (Appendix B)

A chest x-ray or lineogram may be required with referral to the Vascular Access Team.

Central venous access devices are the commonest cause of venous thromboembolism in neonates and children. This can have serious consequences such as catheter malfunction, venous occlusion and a clot embolism.

If a thrombus is suspected **do not use** until an ultrasound of the catheter tip and surrounding veins has been carried out by a radiologist or cardiologist. If a thrombus is present, consideration should be given to removing the catheter and commencing anticoagulants.

Acute onset of symptoms such as dyspnoea, chest pain, syncope, hypoxia, hypotension, tachycardia, tachypnoea, haemoptysis, sweating and fever may be due to pulmonary embolism. In this instance emergency medical attention must be sought.

5.7.5 Tilted Port

If the port is thought to have tilted on palpating refer to Vascular Access Team for immediate advice.

5.7.6 Worn out septum

Ports should last for approximately 2000. If the septum is worn out patients will complain of pain over the port site, the site may be red and swollen and infiltration or extravasation could occur. The port may feel 'wobbly'.
The Vascular Access Team should be contacted.

5.8 Port removal

Removal of a port must be discussed and agreed with the responsible medical/surgical team to confirm resolution of the need for the line to remain in place. Liaise with the Vascular Access Service.

5.9 Discharge Information

Care of the central catheter must be discussed with the patient/family using the Central line booklet which must be provided on discharge (8).

The discharging practitioner must ensure plans are in place for the port to be flushed

Heparin and saline solution with community prescription if required.

6 Education & Training Requirements

Training may be undertaken with a variety of and blended modes of learning: face to face, eLearning, experiential, demonstration of competency etc.

Reporting & Compliance -

The Education & Learning (E & L) department will proactively consult around the E & L needs at BCH NHS FT and plan delivery, commissioning and programmes in response to workforce and service needs. For all core Statutory and Mandatory Training E & L will design and deliver using blending learning approaches, and report compliance through to the Trust Board. It will have in place mechanisms for escalation around non-attendance and compliance, based on the agreed KPI's.

For role essential, role desirable or speciality specific training, the identified lead will be responsible for defining and designing training needs, and will need to ensure that the quality assurance process for education and learning is followed where appropriate. The lead will report compliance within the relevant governance structure.

7 Monitoring Compliance With and the Effectiveness of the policy

7.1 Process for Monitoring Compliance and Effectiveness

Monthly audits of compliance with regard to CVL High Impact Intervention Care Bundles are undertaken in clinical areas.

The IPCT (in conjunction with Informatics) is responsible for ensuring that data regarding compliance with standards for CVL Access; CVL Insertion and CVL On-going Care are displayed on a performance dashboard and monitored closely.

The department managers and lead nurses are responsible for making sure data is inputted in line with deadlines, and also for ensuring actions are taken appropriately should any audit be found to be non-compliant.

Catheter-related bloodstream infections with MSSA require a route cause investigation.

7.2 Standards/Key Performance Indicators

Audit will identify areas of non-compliance and steps will be taken to improve compliance with best practice standards.

8. References

1. Loveday, H.P, Wilson, J.A, Pratt, R.J, Golsorkhi, M, Tingle, A, Bak, A, Browne, J, Prieto, J and Wilcox, M.(2014) epic3: National Evidence-Based Guidelines for Preventing Health care - Associated Infections in NHS Hospitals in England. Journal of Hospital Infection 8651 (2014) S1-S70

2. Royal College of Nursing (2016) Standards for Infusion Therapy 4th Edition. Royal College of Nursing. London.

3. Weinstein, S.M, (2007) Plumer's Principles and Practice of Intravenous Therapy. Eighth Edition. Lippincott Williams ans Wilkins London

4. Dougherty, L. (2008) IV Therapy: recognizing the differences between infiltration and extravasation**.** British Journal of Nursing 17 (14): 896-901.

5. S. Gordy, Rowell, S (2013) Vascular Air embolism. International Journal of Critical Illness and injury Science. (www.ncbi.nlm.nih.gov)

6. L.S, Cook (2013) Infusion-related air embolism. Journal of Infusion Nursing. Vol 36. 1. PP. 26-36

7. BCH Care and Management of Central Venous Lines document

8. 'I Need a Central Venous Line' Information leaflet for young people, Birmingham Childrens Hospital

9. Ben and Jigsaw patient information leaflet

10. Pronovost PJ.Needham, D, Berenholtz.S, Sinopoli, D, Chu. H, Cosgrove. S, Sexton.B, Hyzy. R, Welsh. R, Roth. G, Bander. J, Kepors. J, Goeschel. C An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU, N Engl J Med 2006; 335:2725-2732

11. British Medical Association and Royal Pharmaceutical Society (2016) British National Formulary (2016) Pharmaceutical Press

12. Syner-KINASE (urokinase) (2009) Summary of Product Characteristics.

Appendix A Guidelines for the use of Microclave

Birmingham Children's Hospital NHS
NHS Foundation Trust

Guidelines for Use - MicroClave®

- Remove from packaging and prime the MicroClave® or extension set using an asceptic non-touch technique
- Do not overtighten the MicroClave® device onto the cannula OR hub of a central line when attaching the device
- Scrub the hub of the MicroClave® BEFORE and AFTER each access with a 2% chlorhexidine, 70% alcohol wipe. CLEAN FOR 30 SECONDS AND ALLOW TO DRY FOR 30 SECONDS

- Do not try to access with a needle
- No additional caps/bungs are required on the end of the MicroClave®

- Access with a luer lock OR slip luer syringe. A simple ¼ turn with a slip luer syringe will ensure retention into the device
- When accessing a central line, hold the device **AND** not the hub of the line, to avoid over-tightening
- MicroClave® connectors can remain in place for up 7 days or 600 activations, whichever comes first

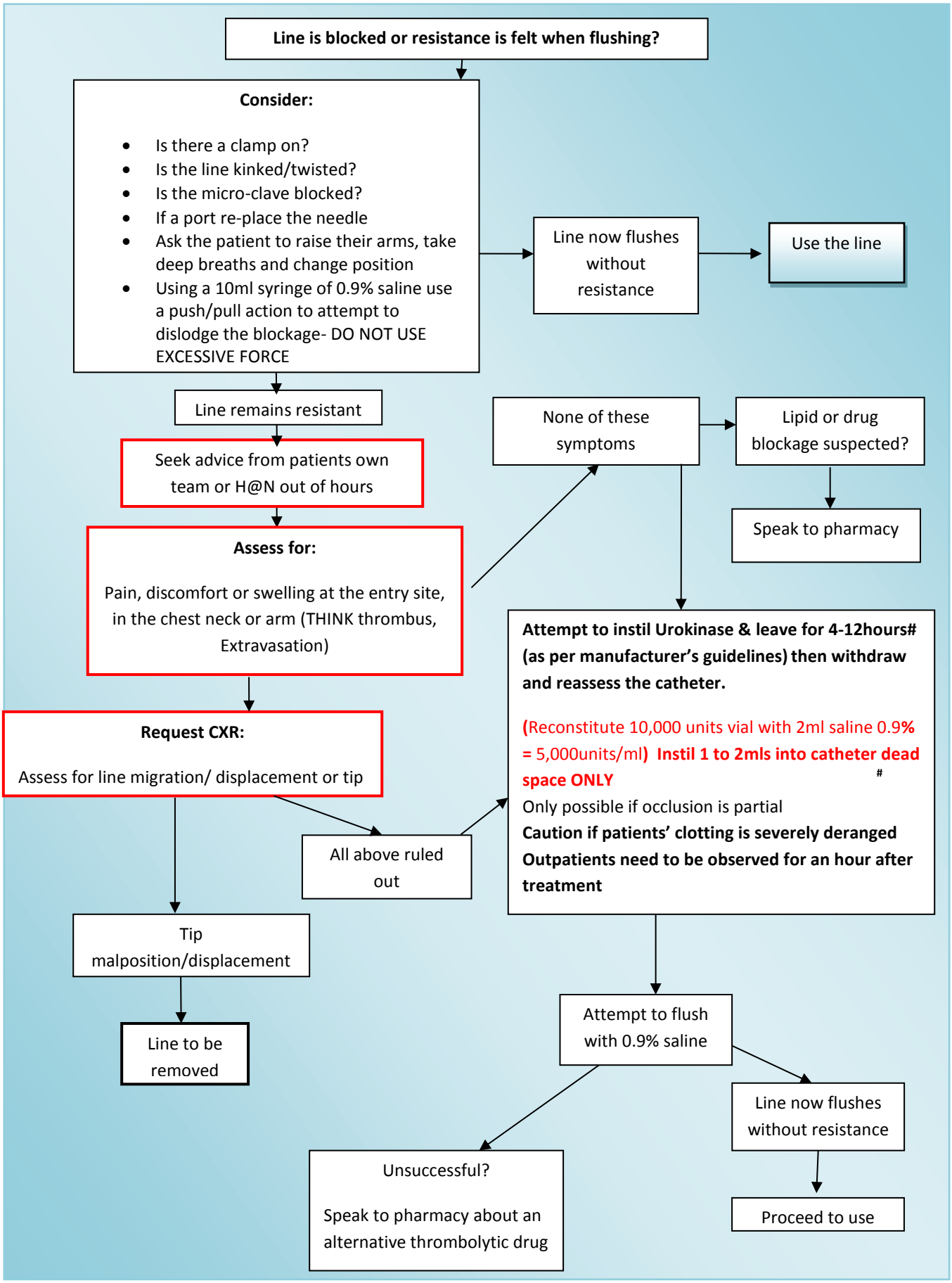
DO NOT PLACE END CAPS ON THE END OF THE MICROCLAVE® –
The MicroClave® is a closed barrier to bacterial colonisation

Fannin
Caring for Life since 1829

If you have any questions regarding the change over please contact: **Ben James**, the Product Specialist from Fannin UK and can be contacted on: 07795 238 368

PART OF DCC VITAL
PHARMA DEVICES LOGISTICS

Appendix B Management of Occluded Central Venous Cathet



Appendix C: Recommended ANTT for Commonly Performed Procedures

Procedure	Technique	Hand Hygiene	Field
Accessing vascuports (i.e. inserting gripper needle into implanted port)	Standard ANTT	Routine	General
Biopsies	Surgical ANTT	Surgical scrub	Critical
Care of wounds healing by primary intention, e.g. surgical incisions	Standard ANTT	Routine	General
Indwelling urinary catheter insertion	Surgical ANTT	Surgical scrub	Critical
Insertion of tracheostomy tubes (surgical)	Surgical ANTT	Surgical scrub	Critical
Suturing of wounds	Standard ANTT	Routine	General
Central venous catheter insertion including Hickman lines and Arterial lines	Surgical ANTT	Surgical scrub	Critical
Chest drain insertion	Surgical ANTT	Surgical scrub	Critical
Emptying of urinary catheter drainage bag	Standard ANTT	Routine	General
Accessing a central venous line to take blood or administer medication	Standard ANTT	Routine	General
Cannulation	Standard ANTT	Routine	General

Appendix D

CVL Access

Birmingham Children's Hospital NHS
NHS Foundation Trust

Ward		Month		Completed by (Print Name)	

Audit No.	Staff Discipline	Hand Hygiene	Access	ANTT Used	Injection Ports
1	Medic Nurse Other	Before AND After Before After Neither	2%CHG/70%IPA Med Dev Wipe Used & Dry 2%CHG/70%IPA Med Dev Wipe Used & NOT Dry Other Used & Dry Other Used & NOT Dry Hub Not Cleaned	Yes No	New sterile cap Not Applicable Same cap replaced
2	Medic Nurse Other	Before AND After Before After Neither	2%CHG/70%IPA Med Dev Wipe Used & Dry 2%CHG/70%IPA Med Dev Wipe Used & NOT Dry Other Used & Dry Other Used & NOT Dry Hub Not Cleaned	Yes No	New sterile cap Not Applicable Same cap replaced
3	Medic Nurse Other	Before AND After Before After Neither	2%CHG/70%IPA Med Dev Wipe Used & Dry 2%CHG/70%IPA Med Dev Wipe Used & NOT Dry Other Used & Dry Other Used & NOT Dry Hub Not Cleaned	Yes No	New sterile cap Not Applicable Same cap replaced
4	Medic Nurse Other	Before AND After Before After Neither	2%CHG/70%IPA Med Dev Wipe Used & Dry 2%CHG/70%IPA Med Dev Wipe Used & NOT Dry Other Used & Dry Other Used & NOT Dry Hub Not Cleaned	Yes No	New sterile cap Not Applicable Same cap replaced
5	Medic Nurse Other	Before AND After Before After Neither	2%CHG/70%IPA Med Dev Wipe Used & Dry 2%CHG/70%IPA Med Dev Wipe Used & NOT Dry Other Used & Dry Other Used & NOT Dry Hub Not Cleaned	Yes No	New sterile cap Not Applicable Same cap replaced

CVL Insertion

Birmingham Children's Hospital NHS
NHS Foundation Trust

Ward		Month		Completed by (Print Name)	

		Aseptic Non-Touch Technique/PPE											
Audit No.	Octenisan pre-insertion wash	Gloves	Drapes	Gown	Operator hat/mask	Eye proctection	Asepsis maintained	Insertion site	Catheter type	Skin preparation	Drressing	Safe sharps	Documentation
1	Yes No	Yes No	Yes No	Yes No	Both Hat only Mask only Neither	Worn Not indicated Not worn but indicated	Yes No	Subclavian Internal Jugular Femoral Other	Single Lumen Multiple Lumen (Indicated) Multiple Lumen (Not indicated)	2%CHG/70%IPA used & dry (Chloraprep) 2%CHG/70%IPA used & NOT dry Other used & dry Other used & NOT dry Skin Not cleaned Not appropriate – alternative product	Biopatch Plus Transparent Transparent only Other dressing	Appropriate Disposal Passed safely (Theatres) Needle & Syringe disassembled Sharp passed hand to hand	Yes person inserting Yes by another Not documented
2	Yes No	Yes No	Yes No	Yes No	Both Hat only Mask only Neither	Worn Not indicated Not worn but indicated	Yes No	Subclavian Internal Jugular Femoral Other	Single Lumen Multiple Lumen (Indicated) Multiple Lumen (Not indicated)	2%CHG/70%IPA used & dry (Chloraprep) 2%CHG/70%IPA used & NOT dry Other used & dry Other used & NOT dry Skin Not cleaned Not appropriate – alternative product	Biopatch Plus Transparent Transparent only Other dressing	Appropriate Disposal Passed safely (Theatres) Needle & Syringe disassembled Sharp passed hand to hand	Yes person inserting Yes by another Not documented
3	Yes No	Yes No	Yes No	Yes No	Both Hat only Mask only Neither	Worn Not indicated Not worn but indicated	Yes No	Subclavian Internal Jugular Femoral Other	Single Lumen Multiple Lumen (Indicated) Multiple Lumen (Not indicated)	2%CHG/70%IPA used & dry (Chloraprep) 2%CHG/70%IPA used & NOT dry Other used & dry Other used & NOT dry Skin Not cleaned Not appropriate – alternative product	Biopatch Plus Transparent Transparent only Other dressing	Appropriate Disposal Passed safely (Theatres) Needle & Syringe disassembled Sharp passed hand to hand	Yes person inserting Yes by another Not documented
4	Yes No	Yes No	Yes No	Yes No	Both Hat only Mask only Neither	Worn Not indicated Not worn but indicated	Yes No	Subclavian Internal Jugular Femoral Other	Single Lumen Multiple Lumen (Indicated) Multiple Lumen (Not indicated)	2%CHG/70%IPA used & dry (Chloraprep) 2%CHG/70%IPA used & NOT dry Other used & dry Other used & NOT dry Skin Not cleaned Not appropriate – alternative product	Biopatch Plus Transparent Transparent only Other dressing	Appropriate Disposal Passed safely (Theatres) Needle & Syringe disassembled Sharp passed hand to hand	Yes person inserting Yes by another Not documented
5	Yes No	Yes No	Yes No	Yes No	Both Hat only Mask only Neither	Worn Not indicated Not worn but indicated	Yes No	Subclavian Internal Jugular Femoral Other	Single Lumen Multiple Lumen (Indicated) Multiple Lumen (Not indicated)	2%CHG/70%IPA used & dry (Chloraprep) 2%CHG/70%IPA used & NOT dry Other used & dry Other used & NOT dry Skin Not cleaned Not appropriate – alternative product	Biopatch Plus Transparent Transparent only Other dressing	Appropriate Disposal Passed safely (Theatres) Needle & Syringe disassembled Sharp passed hand to hand	Yes person inserting Yes by another Not documented

CVL Onging Care

Birmingham Children's Hospital NHS
NHS Foundation Trust

Ward		Month		Completed by (Print Name)	

Audit No.	Line Indicated	Date of Insertion Documented	Appropriate Site Inspection Document	Octenisan given	Dressing			Admin Set Replacement
					Biopatch applied	Transparent	Entry site/Biopatch visible	
1	Still indicated & documented Still indicated & NOT documented Not indicated	Yes No	Yes No	Yes No N/A	Yes No N/A	Yes No	Yes No	Set dated & in date Set dated & NOT in date Set NOT dated N/A
2	Still indicated & documented Still indicated & NOT documented Not indicated	Yes No	Yes No	Yes No N/A	Yes No N/A	Yes No	Yes No	Set dated & in date Set dated & NOT in date Set NOT dated N/A
3	Still indicated & documented Still indicated & NOT documented Not indicated	Yes No	Yes No	Yes No N/A	Yes No N/A	Yes No	Yes No	Set dated & in date Set dated & NOT in date Set NOT dated N/A
4	Still indicated & documented Still indicated & NOT documented Not indicated	Yes No	Yes No	Yes No N/A	Yes No N/A	Yes No	Yes No	Set dated & in date Set dated & NOT in date Set NOT dated N/A
5	Still indicated & documented Still indicated & NOT documented Not indicated	Yes No	Yes No	Yes No N/A	Yes No N/A	Yes No	Yes No	Set dated & in date Set dated & NOT in date Set NOT dated N/A