

Paediatric and NNU Peripheral Vascular Devices Record

Key Document code:	WAHT-TP- 083	
Key Documents Owner:	Dana Picken	Consultant Paediatrician
Approved by:	Paediatric Quality Improvement meeting	
Date of Approval:	9 th February 2024	
Date of review: This is the most current version and should be used until a revised document is in place	9 th February 2027	

Key Amendments

Date	Amendment	Approved by
19 th Nov 2020	Document extended for 1 year	Dr J West/Paediatric QIM
26 th March 2021	Approved with no amendments	Paediatric QIM
9 th Feb 24	Document approved with no amendments	Paediatric guideline review day

Patient name

Hospital No

DOB.....

Ward.....Cons



Worcestershire Acute Hospitals NHS Trust

PERIPHERAL VASCULAR DEVICES (PVD) RECORD

Patient Ward (specify) _____ Ward/Dept. where cannula inserted: _____

Date of Insertion:/...../..... Time of insertion: am pm Chloraprep used:

Insertion Site: Left Right Hand Wrist Forearm Anti Cubital Fossa Other (please specify)

Cannula Size / Gauge: (circle) 14G 16G 17G 18G 20G 22G 24G 26G Orange Grey White Green Pink Blue Yellow Purple

SIGNATURE of person

Inserting cannula: PRINT NAME:

Designation: (please circle) Doctor / Nurse / Midwife / Paramedic / Theatre / Generic Worker

Date/time and person inserting cannula unknown (tick box if appropriate)

CANNULA TO BE FLUSHED 8 HOURLY AS A MINIMUM. Consider removing cannula if not used for 24 hours

Table with 7 columns: DAY, DATE, TIME, CANNULA REMOVED, PHLEBITIS SCORE, ACTION TAKEN/COMMENTS, Signature. Rows 1-3 for each day.

Date Cannula removed:/...../.....

PHLEBITIS SCORE ON REMOVAL OF CANNULA: _____

FLUSHES ADVICE

Table with 2 columns: Device type, Flush advice. Rows: Peripheral Lines, Peripherally inserted Central Line Catheters (PICC/Long Lines), Neonatal Peripheral & Long Lines.

SODIUM CHLORIDE IV FLUSHES

For other flushes prescribe on regular or as required section on Drug Chart

Table for SODIUM CHLORIDE IV FLUSHES with columns for Date, Time, Dose, Route, Sig, and a section for DRUG (APPROVED NAME), DOSE, ROUTE, DIRECTIONS, START DATE, SIGNATURE, BLEEP.

PHARMACY USE										
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FLUID ADMINISTRATION RECORD

1 Date of connection:/...../..... Time of connection: :
 Cannula Site: Right/Left Hand Wrist Forearm Anti Cubital Fossa Other (please specify)

Fluid Administered: (circle) Crystalloid Colloid Blood TPN Other

SIGNATURE of person
 Connecting administration Set: **PRINT NAME:**

Designation: (please circle) Doctor / Nurse / Midwife / Paramedic / Theatre / Generic Worker

Date/time and person unknown (tick box if appropriate)

SET	DATE	TIME	CANNULA REMOVED	PHLEBITIS SCORE	ACTION TAKEN/COMMENTS	Signature
1st			YES / NO			
2nd			YES / NO			
3rd			YES / NO			

Date set removed/replaced: .../.../... REMOVE/REPLACE NO LATER THAN 3 DAYS AFTER CONNECTION

Administration sets must be replaced:

- Immediately following administration of blood or blood products
- After 24 hours following parenteral nutrition (72 hours if no lipid)
- After 72 hours for all other fluid sets
- After 24 hours following other IV medications (e.g. Insulin, Morphine)