

PERIPHERAL INTRAVENOUS CATHETERS - CLINICAL STANDARD PRACTICE GUIDELINE[®]

DOCUMENT SUMMARY/KEY POINTS

- This document outlines the principles of venepuncture and inserting, securing and monitoring a peripheral intravenous cannula (PIVC) in the paediatric patient.
- This document is guided by the <u>ACSQHC Management of Peripheral Intravenous</u> <u>Catheters Clinical Care Standard May 2021¹</u>
- Clinicians who insert, manage, and remove PIVC's must have completed training, education and assessment. Recognition of prior learning will apply.
- This document outlines the accreditation process for RNs & ENs (where venepuncture and intravenous cannulation is part of their clearly defined role and identified within their position description) to undertake cannulation.
- Only **two attempts** by an individual clinician to perform venepuncture or insert a PIVC shall be undertaken. This includes any puncture of the skin irrespective of whether the vein has been punctured.
- Daily review and assessment is required for the necessity for the cannula to remain in place and remove if no longer required: this includes documenting in the patient notes.
- Cannula site "checks" are required **every hour** with fluids or **every four hours** if capped and documented in eMR.
- All children with a PIVC cannula with or without fluids, are to have documentation notated in the clinical record for *every shift*.
- Any adverse outcomes e.g. extravasation or pressure injuries are documented in IMS+.

Safety Alert: Be aware that any patient with cyanotic heart disease and right to left shunting may be at risk of systemic air embolism with introduction of air into the venous system.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

1	Approved by:	SCHN Policy, Procedure and Gu			
Date Effective: 1 st November 2024			Review Period: 3 years		
٦	Team Leader:	Vascular Access CNS2 and NE		Area/Dept: Vascular Access & ED	
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CHANGE SUMMARY

- Therapeutic Hold pictures removed as don't align with infection prevention and control principles.
- Update to SCHN Nurse Accreditation
- Updated links to resources and other policies.
- **12/06/25:** Minor review. Removed *Venepuncture and Cannulation Education for Accreditation Presentation* from Appendix 4 Resources section and the Education Tab on ePolicy.

READ ACKNOWLEDGEMENT

• Medical staff, RNs, ENs and relevant managers are to read and acknowledge having read and understood the contents of this document.

NOTE: Training/Assessment Required – Accreditation procedures for RNs and ENs.

• Where sedation may be required see Section 8.11 in the <u>SCHN Procedural Sedation</u> <u>Guideline</u>

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

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Purpose

To provide:

- high quality care and reduce complications associated with inserting, managing and removal of PIVC's,
- clinicians' guidance for training and consistent practice in inserting and maintaining PIVC's, and
- timely and safe intravenous access for paediatric patients.

Introduction

Peripheral intravenous cannulation (PIVC) and venepuncture are procedures often used to establish a route for medication and/or fluid administration or to obtain a sample of blood for testing.

Quick facts about PIVCs¹

- Up to 70% of hospitalised patients require at least one PIVC at some point during their hospital stay
- Between 4% 28% of PIVCs inserted are not needed. This increases to 50% in the emergency department, where a PIVC is often inserted "just in case"
- Up to 69% of PIVCs are associated with complications, leading to up to 90% of PIVCs being removed before therapy is finished
- If a patient has one PIVC fail, the risk of future PIVCs failing is greater.
- First insertion success rates are poor. First insertion attempts fail in up to 40% of adults and in up to 65% of children.

The <u>SCHN Improving PIVC Insertion</u> is a simple set of practices that help guide clinicians to improve patient outcomes when considering vascular access.

Scope

The document outlines the minimum standards to ensure safe cannulation and care of a PIVC.

All clinicians who are responsible for venepunctures and the insertion and ongoing management of a PIVC must be appropriately qualified and trained to do so within their scope of practice.

Nurses who have successfully completed Sydney Children's Hospital Network (SCHN) venepuncture and cannulation course and have fulfilled ongoing accreditation requirements are able to:

• Cannulate at the request of a Medical Officer or Nurse Practitioner.



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- Site/resite cannula for patients with orders for intravenous therapy after clarification by the medical officer or Nurse Practitioner.
- Perform venepuncture for the purpose of collecting blood at the request of the Medical Officer or Nurse Practitioner, and for the purpose of collecting samples when pathology staff are un-available.

The following procedures are *not included within the scope* of this document:

- Insertion and management of <u>Central Venous Access Devices</u>, administration of Parenteral Nutrition, transfusion of blood and blood components and insertion and management of arterial or umbilical lines.
- <u>Intra-osseous</u> insertion and management.

Standard 1 - Assess intravenous access needs

- Consider the need for a PIVC and whether other options may be appropriate eg oral, intramuscular, or nasogastric ¹.
 - Refer to the Venous Access Decision Pathway <u>SCH</u>, or <u>CHW</u> and PIVC Access -Decision & Escalation Pathway (<u>Appendix 1</u>)⁴, to determine whether peripheral, midline or central access is most appropriate.
- Assess whether peripheral or central venous is appropriate ¹: (Refer to <u>Appendix 2</u> <u>DIVA Scoring Tool</u> for more information)
 - o medical history, age, clinical condition, comorbidities
 - o prescribed therapy, anticipation of duration of therapy
 - $_{\circ}$ $\,$ history of vascular access and infusion therapy and complications
 - $_{\odot}$ $\,$ resources and ability to care for the device.
 - o availability of appropriate insertion sites and likelihood of first-time insertion
- Discuss and ascertain that the patient (if appropriate) and carers understand the need for IV therapy, especially if multiple options are available, specific clinical issues need to be raised about the therapy, or if the carer has concerns. Document the outcome of the discussion as part of the informed consent process ¹.
- Selection of the most appropriate vascular access device occurs as a collaborative process among the multidisciplinary team, the patient and the patient caregivers.



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Standard 2 - Inform and partner with patients and carers

- Verbal consent should be obtained from the child and/or guardian prior to the procedure. To obtain informed consent the health practitioner who performs the procedure must inform the child and/or guardian of the risks, discuss the necessity of the PIVC and explain the procedure ^{14, 17}.
- Children 14-16 years may be considered mature minors and may be able to give consent or refuse treatment ¹⁴. If a Medical Practitioner assesses a Minor competent (also known as a Mature Minor) and the Minor can give valid consent, then the consent of the parent or guardian will not be required. However, where the Minor agrees, it is good practice to involve the family in the decision-making process where appropriate ¹⁴.
- Invite the patient/carers to ask questions, and use methods such as <u>teach-back</u> to confirm they understand the information they have received ¹.
- Confirm patient identity, procedure, allergies & consider anticipated critical / adverse events as per NSW Health <u>Clinical Procedure Safety Policy Directive</u>⁵.
- Provide the Factsheet "<u>The facts about drips</u>" to parents and carers.
- Developmental age and condition will guide the clinician in appropriate preparation of the infant/child for the procedure. Partner with parents/carers to plan best approach to procedure.
- Where possible the child life therapist should be involved in helping prepare the child and family. See <u>Child Life Therapy Procedure Support Guideline</u>.
- Ideally the procedure should be performed in a procedure room. Distraction tools appropriate to developmental age should be utilised.
- See <u>Appendix 4 for IV-WISE patient discussion tool</u>¹.

Standard 3 - Ensure competency

- Clinicians who insert, manage, and remove PIVC's must have completed training, education and assessment ¹. Recognition of prior learning will apply.
- Clinicians must maintain continuing education and practice to ensure skills and knowledge remain in line with current practice recommendations and competency is maintained ¹.
- Nurses performing intravenous cannulation and venepuncture must hold current accreditation to do so or be participating in the accreditation program.
- Nurses eligible to undertake the accreditation program are nurses who, with approval from their Line Manager and upon accreditation, will work in areas where intravenous cannulation and venepuncture occur.
- Nurses must have successfully completed both the SCHN Cannulation and Venepuncture Theoretical Learning and specific cannulation and venepuncture practical program of education ¹⁹. <u>See Appendix 4.</u>
- Accredited nurses are approved to insert an intravenous cannula into the peripheral veins of the upper and lower limbs. Theatre staff are an exception to this principle as type of surgery may affect limbs available for cannulation.



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Standard 4 - Choose the right insertion site and PIVC

- Look carefully with a tourniquet for the most suitable vein and remember that in paediatric patients the best vein may not necessarily be palpable. See <u>Appendix 2 for</u> <u>DIVA Scoring Tool</u> ^{7, 10}.
- Dorsum of the non-dominant hand is preferred the vein running between the 4th and 5th metacarpals is most frequently used.
- In addition to the usual sites in adults, commonly used sites in children include the volar aspect of the forearm ^{10, 21}.
- Consider practicalities of splinting (e.g. elbow, foot in a mobile child).
- Scalp veins should only be used by more experienced doctors or Neonatal Nurse Practitioners (shaved scalp hair re-grows very slowly).
- Where possible avoid areas of flexion (e.g. wrist or cubital fossa) and lower extremities unless necessary.
- Device selection should be based on the principle of the smallest possible device for the completion of treatment.
- PIVCs range from 24 gauge (most commonly used in neonates and infants) to 14 gauge, which is infrequently used in paediatrics but may be required in various situations including trauma, fluid resuscitation or blood transfusions in adolescents.
- <u>See Appendix 2</u> for characteristics and indications of PIVC gauges in paediatrics and for Vein Identification Scale ^{10,12,18}.
- Ultrasound evaluation of veins is an invaluable resource to assess venous course, identify underlying structures such as arteries and nerves and ensure venous patency before venous puncture ¹².
- Real-time ultrasound guidance has been shown to reduce complications, procedure time, and improve first time puncture and overall success of peripheral catheter placement.
- Ultrasound for PIVC insertion facilitates choice of catheter length that will ensure sufficient catheter is residing within the vein lumen.
- Only clinicians trained in Ultrasound Vascular Access should attempt this method of cannulation ¹².



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Standard 5 - Maximise first insertion success

- If clinical presentation of a patient is such that the likelihood of inserting a PIVC successfully on the first attempt is low given your current experience, follow the PIVC Access Decision & Escalation Pathway (<u>Appendix 1</u>)^{4,18}.
- Where clinically appropriate the use of local/topical anaesthetic (LMX,) should be used ^{18, 22}.
- It may be necessary to hold a child gently but firmly during clinical procedures to maintain the child's safety and prevent injury. Holding is distinguished from restraint by the degree of force required and the intention.
- <u>Age-appropriate distraction</u> and reward techniques should be used in conjunction with therapeutic holding techniques. ²⁰.
- Neonates benefit from oral sucrose or expressed breast milk (up to 0.5mL for either) with a dummy as a pain management strategy. Refer to the <u>Sucrose Nurse Initiated</u> <u>Medication¹¹</u>.
- Occasionally sedation such as nitrous oxide or oral midazolam may be required for cannulation. This should be discussed with a senior registrar or consultant and carried out as per:
 - <u>SCHN Procedural Sedation (Paediatric Ward, Clinic and Imaging Areas) Practice</u> <u>Guideline,</u>
 - <u>Procedural Sedation in the Emergency Department SCH</u> Practice Guideline or
 - Paediatric Sedation in the Emergency Department CHW Practice Guideline.
- Only 2 attempts to perform venepuncture or insert a PIVC shall be undertaken by any staff member (medical or nursing), unless there are exceptional circumstances. In this case further attempts must be discussed with the senior clinician. This includes any puncture of the skin irrespective of whether the vein has been punctured. Refer to the PIVC Access Decision & Escalation Pathways (<u>Appendix 1</u>)^{4, 18}.
- When the insertion of a PIVC has been unsuccessful or it is deemed unlikely to succeed, the Medical Officer responsible for the child's medical care must formulate an appropriate plan. Refer to the Venous Access Decision Pathway <u>SCH</u>, or <u>CHW</u> and PIVC Access - Decision & Escalation Pathways (<u>Appendix 1</u>)^{4, 18}.
- A medical order for intravenous fluids, blood products, serial blood sample collection or the administration of medication will constitute a medical order for the insertion of a PIVC.

Local Work Procedures:

- <u>Cannulation</u>
- <u>Venepuncture</u>





Standard 6 - Insert and secure

- PIVC cannulation and venepuncture are procedures requiring aseptic non-touch technique (ANTT). "The aim of aseptic non touch technique is to prevent the transmission of micro-organisms to wounds or susceptible sites, to reduce the risk of infection." An <u>ANTT</u> risk assessment should be conducted to determine use of Standard or Surgical ANTT for the cannulation procedure ^{1, 10, 15}.
- Skin preparation is essential to reduce risk of infection.
 - 0.1% Aqueous Chlorhexidine is recommended for skin antisepsis in neonates and infants up to 8 weeks of age due to risks of skin irritation and chemical burns if a stronger skin prep is used.
 - 2% Chlorhexidine Gluconate in 70% alcohol is used for skin preparation in children greater than 8 weeks of age
- Before applying the semipermeable dressing swab area around insertion site with a barrier film e.g. Cavilon[™] to protect the skin from adhesive-related injury and may also assist in improving security of dressing ²¹.
- Sterile, bordered, transparent semi-permeable dressings ¹⁰ are to be used to secure the PIVC. Consider patients allergies to tapes.





- Splinting should only be used on areas of flexion ¹⁰ (e.g. wrist, elbow joint), ensuring that the fingers / toes remain exposed. Use elasticised tape/ Foam tapes (securer/Microfoam) to secure limb to arm board.
- Ensure that PIVCs are labelled in accordance with the <u>National Standard for User-applied Labelling of</u> <u>Injectable Medicines, Fluids and Lines</u>^{1, 13}.



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Crepe bandages should not be used to wrap limbs with PIVC's in-situ as the site must be visible for inspection hourly. If a form of covering is required due to risk of patient removing PIVC use Tubifast / Tubinet to enable easy viewing of the site hourly.





Standard 7 - Document decisions and care

- Mandatory documentation must be completed by clinicians performing the PIVC insertion procedure and should be recorded in the patient clinical notes ¹ in eMR (Interactive View and I&O) OR in the NETS paperwork, including:
 - o Insertion site, laterality and gauge
 - o Insertion date and time
 - Inserted by (SCHN, Ambulance or External Facility)
 - Insertion performed by (proceduralist name)
 - Inserted in emergency situation (yes/no)
 - Insertion number of attempts
 - Insertion analgesia agents used
 - Ultrasound use during insertion
 - Indication for insertion
 - Dressing and securement applied on insertion
- Unsuccessful cannulation attempts should be documented in the patient's progress notes. Documentation should include consent, time, date, location of unsuccessful cannulation attempt and if blood was collected.
- If any adverse event occurred during the procedure of insertion of a PIVC, the Medical Officer responsible for the child's medical care shall be notified immediately and the event entered into IMS+ by the staff who attempted the cannulation.
- **PIVC mandatory site checks** are to be documented every hour or if the patient or carer raises concerns in eMR or in NETS paperwork. For eMR documentation Interactive View and I&O, this includes:
 - Site check (Touch, Look, Compare)
 - Site condition assessment
 - o Patency
 - Dressing intact
 - IV set changed (only at time of completion)
- Additional optional PIVC pump pressure checks will depend on a number of factors such as the size of the vein, rate at which fluid is being infused, type of fluid being infused, and size of the cannula. The monitoring and documentation of pump pressure may be useful in monitoring the trend but does not replace visualisation of the site.

(see over page)



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V PACU		
🗙 Fluid Balance Chart		
🗙 Quick View	Find Item Critical H	igh 🗌 Low
🗙 Lines - Tubes - Drains	Result Cor	mments Flac
CVAD Care		
Peripheral IV Cannula		
Epidural and Regional Infusion Line Care Subcutaneous (SubCut) infusions Enteral Tube Urinary Catheter	前 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	13:00 - 13:59
Bladder inigation	Peripheral IV Cannula	e
Chest Drains	Arm Right	
Stoma	⊿ Hand Right 22g (Blue)	
CSF Drainage Care	Inserted date/time	29/11/202
Intracranial Pressure Monitoring	♦ Inserted by	SCHN
AV Fistula Care	IV Insertion performed by	Wallace, S
	Inserted in emergency situation	No
	Insertion number of attempts	1
	Insertion analgesia agents	Topical an
	Ultrasound used (competent staff	Yes
	Indication for insertion	IV Medica
	Dressing applied on insertion	Tegaderm
	Site check	Touch, Lo
	Site condition	No compl
	Patency	Flushes wi
	Dressing intact	Yes
	Set changed	30/11/2021
	Removed date/time	01/12/202
	Removed by	Wallace, S
	Reason for removal	Difficult to
	Peripheral IV Cannula comment	
	Extravasation identified	Yes
	Stage of extravasation	Stage 1
	Extravasation comment:	

Standard 8 - Routine use: inspect, access and flush

- Routine inspection of the PIVC site is performed EVERY HOUR if infusions are running or 4-6th Hourly if the PIVC is capped for signs of complications including ¹:
 - o Site check (See SCHN PIVC Prompt Care for Clinicians: Touch, Look, Compare)
 - Site condition assessment (pain, oedema, ooze, erythema, site leakage, thrombophlebitis, pressure injury, hot to touch, decreased capillary refill)
 - Patency
 - Dressing intact
- If concerns refer to <u>SCHN IV Extravasation Management Practice Guideline</u> for guidance on management.
- Discuss with parent/carer any concerns regarding the PIVC and their understanding of the continued need for PIVC. Ensure parents/carers have the <u>TLC: Touch, Look and</u> <u>Compare Information Sheet</u> and know what signs and symptoms they should report and advise of the importance of telling the clinician of their concerns if any.
- There is insufficient evidence to support the theory that heparin prolongs the life of a PIVC, therefore cannula flushing unless otherwise indicated (e.g. limited circulatory volume) is to be with 0.9% sodium chloride ^{8, 10}.



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- In most cases, intermittent infusions will not affect the life of the cannula and the significant advantage noted in the literature ^{1, 10} is the practice allows the infant/child or young person to become more mobile and easier to care for in the Hospital environment.
- <u>Aseptic Non Touch Technique</u> precautions should be used when performing PIVC care procedures.
- Decontaminate access ports before and after access by scrubbing the hub for 20 seconds and allowing to visibly dry prior to accessing the PIVC.
- If PIVC is capped, flush with 0.9% sodium chloride 4-6 hourly to reduce risk of blockage and prevent mixing of incompatible medicines or fluids.
- Any adverse outcomes e.g. extravasation injuries are documented in IMS+.

Standard 9 - Review ongoing need

- Review and document the ongoing need for a patients PIVC at least once per day or more often if clinically indicated ¹.
- Review whether switching form IV to oral therapy is possible.
- Remove PIVC immediately if no longer required.

Standard 10 - Remove safely and replace if needed

- Remove PIVCs as soon as they are no longer needed or if complications occur ¹. In the case of an extravasation injury, consult the recommendations for management in the <u>SCHN IV Extravasation Management Practice Guideline</u> prior to PIVC removal.
- Document the reason for removal and the condition of the site.
- Provide written discharge advice for signs to look out for after removal of PIVC and who they should contact if signs of infection develop.
- Do not routinely replace PIVCs in neonates and children. Replace with a new PIVC if IV therapy still required. If extended IV therapy anticipated consider alternative device e.g. central venous access device.
- **PIVC Removal documentation** must be completed in eMR (Interactive View and I&O) **OR** in the NETS paperwork, including:
 - $_{\circ}$ Removal date and time
 - Removed by (proceduralist)
 - Reason for removal
 - Extravasation identified (yes/no) including Stage of Extravasation injury if identified

ALERT: When removing a PIVC, avoid using sharps and/or scissors to remove tapes and dressings as this may cause injury or harm to child.



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Appendix 1- Decision & Escalation Pathway

SCH – PIVC Access - Decision & Escalation Pathway

Peripheral IV access required

Consider alternative routes (PO/NG/IM/SC/IO) Use comfort, pain management and distraction techniques measures with every attempt

ASSESS URGENCY





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CHW – PIVC Access Decision & Escalation Pathway



- Discuss alternatives with Admitting Consultant/Senior Consultant on shift (PO,NG,IO,IM,SC), consider skill set within individual teams
- Call for assistance: Anaesthetic Consultant (#6777)
- Consider if central venous access may be required
- Consider consulting with CNS2 Vascular Access for further management (6763) Monday-Friday 0730-1600

Occasionally a senior, experienced clinician may need to exceed 2 attempts or have a break and then retry if no other experienced clinicians are readily available.



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NETS – PIVC Access Decision & Escalation Pathway





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Appendix 2 - DIVA Scoring Tool & PIVC size and use ^{10, 18}

Predictor	0 Points	1 Point	2 Points
Visible Vein	Visible	-	Not visible
Palpable Vein	Palpable	-	Not Palpable
Age	≥ 36 months	12-35 months	< 12 months

DIVA Scoring Tool (Difficult Intravenous Access)

GAUGE and Length	Usual age	Purpose
26 G (NICU) 24 G	Neonates Infants	Most infusions Maintenance infusions Small superficial vessel
22 G (short)	Toddlers and school ages	Most infusions Minimal adiposity
22 G (long)	Toddlers and school ages	Ultrasound guided insertion Excessive adipose tissue Longer required duration of therapy
20 G (short)	Older school age and adolescence	Intraoperative Trauma, fluid resuscitation, Blood sampling on insertion Most infusions Minimal adiposity
20 G (long)	Older school age and adolescence	Ultrasound guided insertion Excessive adipose tissue Longer required duration of therapy
>20 G and up to 14 G	Older school age and adolescence	Intraoperative Trauma, fluid resuscitation, Blood sampling on insertion Most infusions



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Appendix 3 – IV WISE patient discussion tool ¹

The IV-WISE patient discussion tool

IV-WISE* lists key discussion points for clinicians and patients, to involve patients in their care and prevent PIVC-related complications:

What clinicians should discuss with patients:	What patients can ask and do:
Intravenous access needs	
 Discuss why IV fluids or medicines are needed Explain how the PIVC will be inserted Ask patients about their PIVC history and any current needs. 	 Tell your healthcare team about your past experiences including: Difficulty inserting a PIVC Anything that has worked well Your preference or any physical problems that could affect where the PIVC is placed Any allergies you have, such as to tapes and dressings
Vascular access checks	
 Advise that the PIVC will be checked regularly Ask patients to report any concerns or any problems they notice (e.g. redness, swelling). 	 Your clinician will regularly check your PIVC Tell your clinician if you have any concerns or notice any problems.
What patients can do to reduce the risl	k of complications
 Advise patients what they can do to help reduce the risk of PIVC-related complications and infection Provide patients with the 'Looking after your cannula' information sheet. 	 To help to look after your PIVC: Protect the PIVC from knocks or being pulled Wear loose clothing so that the PIVC does not get caught Keep the PIVC dry while washing and showering Ensure that the protective dressing stays in place.
Infection risk	
 Discuss how to prevent infection. 	 To prevent infection: Keep your hands clean by washing with soap or using sanitiser Do not touch, fiddle with, or move the device.
Signs and symptoms of complications	
 Discuss the signs and symptoms to look out for When removing the PIVC, advise patients that symptoms can occur up to 48 hours later and what to do. 	 Tell your clinician as soon as possible about: Redness, pain or swelling at the insertion site Feeling hot, cold or shivery Leakage from the device The dressing getting wet, bloodstained or loose.
E Expected removal	
 Tell patients when the PIVC is expected to be removed (e.g. when therapy is finished). 	 If your PIVC has not been used in the last 24 hours, as if you still need it If you are going home and your PIVC is still in place, ask your clinician if it can be removed.
Australian Commission on Safety and Quality in Hea Catheters Clinical Care Standard May 2021 ¹	Ithcare Management of Peripheral Intravenous
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Appendix 4 - SCHN Nurse Accreditation

Resources:

- <u>Cannulation Clinical Skills Assessment</u>
- <u>Cannulation Clinical Skills Assessment Assessors Guide</u>
- <u>Venepuncture Clinical Skills Assessment</u>
- Venepuncture Clinical Skills Assessment Assessors Guide
- <u>Venepuncture and Cannulation Workshop Presentation</u>

SCHN Nurse Accreditation





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- Initial education in technique must be performed on a mannequin until satisfactory level of skill is obtained before progressing to supervised practice on patients.
- Nurses must practice under the supervision of a clinician who is accredited for cannulation.
- To obtain initial PIVC cannulation accreditation, there must be a minimum of five (5) successful cannulations. Accreditation must be completed by an SCHN accredited assessor
- To obtain initial venepuncture accreditation, there must be a minimum of five (5) successful venepunctures. Accreditation must be completed by an SCHN accredited assessor
- To retain accreditation for PIVC cannulation or venepuncture, the nurse must maintain competency through regular practice and supporting documentation as evidence as required.
- Nurses employed at SCHN with prior venepuncture and intravenous cannulation accreditation from another institution can apply for "Recognition of Prior Learning" with the local CNE/NE and a plan can be developed.
- Accreditation of nurses in intravenous cannulation and/or venepuncture will be recorded in MyHealth Learning.
- The Clinical Nurse Educators, Nurse Educators or delegate of an area where intravenous cannulation and venepuncture occur on a regular basis, are responsible for supporting the nurse during the accreditation program (supporting both theoretical learning and skills acquisition).
- It is the professional responsibility of each nurse to approach the NE/CNE and/or Manager if additional/ongoing training and assessment in this extended skill is identified.
- Reassessment of intravenous cannulation or venepuncture is required only when a new practice change is implemented or as identified for an individual this may be self-identification or identified by a colleague.



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Appendix 5 - Product Reference Guide

PIVC BORDERED DRESSINGS

Instructions for use are included in the product packaging and further information can be found on the <u>IV house website</u> which includes <u>Instruction videos</u>.

Product Description & Product Code	
Tegaderm [©] IV Advanced Bordered Dressings	
1683 adult	
Tegaderm [©] IV Advanced Bordered Dressings	
1680 neonate	
Tegaderm [©] IV Advanced Bordered Dressings	
1682 paediatric	
Tegaderm [©] IV Advanced Bordered Dressings	
1683 older children-adults	



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Procedure No: 2013-9077 v5.1 Procedure: Peripheral Intravenous Catheters - Clinical Standard



Microfoam tape	Non-sterile foam tape, can be used for placement under PIVC hub to assist in prevention of pressure area development.
Sorbaview Shield [©] Pediatric Peripheral SV226UDT Peripheral SV233UDT	
	Paediatric Peripheral Peripheral





949XS-Foot

9495-Foot

Newborns 0-4 months, or 2.5-7 kg

Infants 4–12 months, or 6–12 kg Hay fit larger infants. Nonambulatory infants only.

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I.V. House Products at a Glance





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References

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