

# INVASIVE PROCEDURE SAFETY CHECKLIST: CVC Insertion

| BEFORE THE PROCEDURE   |                              |                                     | TIME OUT  |                              |                             | SIGN OUT  |                              |                             |
|--|------------------------------|-------------------------------------|---|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| Any known drug allergies?  | Yes <input type="checkbox"/> | No <input type="checkbox"/>         | Verbal confirmation between team members before start of procedure  |                              |                             | Correct injection site caps placed using sterile technique    | Yes <input type="checkbox"/> |                             |
| Coagulation checked?   | Yes <input type="checkbox"/> | No <input type="checkbox"/>         | Is patient position optimal?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Sterile dressing  | Yes <input type="checkbox"/> |                             |
| Is all equipment available? (including ultrasound if applicable)   | Yes <input type="checkbox"/> | No <input type="checkbox"/>         | All team members identified and roles assigned? (assistant to provide prompt for wire removal during procedure) | Yes <input type="checkbox"/> |                             | <b>Guidewire removed?</b>                                     | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Sterility of operator (hands scrubbed, appropriate personal protective equipment worn)                                       | Yes <input type="checkbox"/> |                                     | Correct line ready / integrity of line checked  | Yes <input type="checkbox"/> |                             | Chest X-Ray required/ordered                                  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2% Chlorhexidine Gluconate / 70% isopropyl alcohol formulation (Chloraprep 2%) applied to procedure site and allowed to dry? | Yes <input type="checkbox"/> |                                     | Any concerns about procedure?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Any adverse events? (Documented in adverse events Log)        | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Use a large drape to cover the patient in a sterile manner   | Yes <input type="checkbox"/> |                                     | If you had any concerns about the procedure, how were these mitigated?  |                              |                             | Transduce CVC   |                              |                             |
|  |                              |                                     |   |                              |                             | CVP waveform present  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|  |                              |                                     |   |                              |                             | Record CVP -            mmHG                                  |                              |                             |
|  |                              |                                     |   |                              |                             | If any concerns perform paired CVC gas and ABG.               |                              |                             |
|  |                              |                                     |   |                              |                             | pO <sub>2</sub> CVC =            pO <sub>2</sub> ABG =        |                              |                             |
|  |                              |                                     |   |                              |                             | <b>Signature of responsible clinician completing the form</b> |                              |                             |
|  |                              |                                     |   |                              |                             |   |                              |                             |
| Procedure date:  | <input type="text"/>         |                                     | Patient Identity Sticker:   |                              |                             |   |                              |                             |
| Time:  | <input type="text"/>         |                                     |   |                              |                             |   |                              |                             |
| Operator:  | <input type="text"/>         |                                     |   |                              |                             |   |                              |                             |
| Observer:  | <input type="text"/>         |                                     |   |                              |                             |   |                              |                             |
| Assistant:   | <input type="text"/>         |                                     |   |                              |                             |   |                              |                             |
| Level of supervision:  | SpR <input type="checkbox"/> | Consultant <input type="checkbox"/> |   |                              |                             |   |                              |                             |
| Equipment & trolley prepared:  | <input type="text"/>         |                                     |   |                              |                             |   |                              |                             |

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| During the procedure  |                              |
|---|------------------------------|
| Sterile gloves and sterile gown worn by operator and assistant            | Yes <input type="checkbox"/> |
| Hat and mask worn by operator and assistant                               | Yes <input type="checkbox"/> |
| Sterile field maintained  | Yes <input type="checkbox"/> |
| Sterile sheath and sterile gel used with ultrasound probe (if applicable) | Yes <input type="checkbox"/> |

| Procedure   | Catheter type                              | Insertion site                                    |                               |
|---|--|---|-------------------------------|
| <input type="checkbox"/> Elective   | <input type="checkbox"/> Multi-lumen       | <input type="checkbox"/> Subclavian               |                               |
| <input type="checkbox"/> Emergency  | <input type="checkbox"/> Dialysis          | <input type="checkbox"/> Jugular                  |                               |
| <input type="checkbox"/> Re-wire  | <input type="checkbox"/> Introducer/Sheath | <input type="checkbox"/> Femoral                  |                               |
| Ultrasound used?<br>Yes <input type="checkbox"/><br>No <input type="checkbox"/> | <input type="checkbox"/> PICC/ Midline     | <input type="checkbox"/> Right                    | <input type="checkbox"/> Left |
|   | <input type="checkbox"/> ECMO / VAD        | Guidewire Removed<br>Yes <input type="checkbox"/> |                               |

| CXR Review                  |                              |                             |
|-----------------------------|------------------------------|-----------------------------|
| Appropriate position on CXR | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Further actions required:   |                              |                             |
|                             |                              |                             |

| Complications  |  |                                      |                                      |
|--|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Pneumothorax                    | <input type="checkbox"/> Arterial puncture / placement (follow unit policy for management) | <input type="checkbox"/> Malposition | <input type="checkbox"/> Haemorrhage |
| <input type="checkbox"/> 2 <sup>nd</sup> person required | <input type="checkbox"/> Unable to cannulate   | <input type="checkbox"/> Other       | <input type="checkbox"/> None        |
| Complication Actions/Comments:                           |  |                                      |                                      |
|  |  |                                      |                                      |