fraserhealth

# REGIONAL PERIPHERAL IV (PIV) & EXTENDED DWELL PIV (EPIV) INSERTION & MAINTENANCE RECORD

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## PIV / EPIV insertion

PN – if further documentation in Progress Notes

| Date (dd/mm/yyyy) | Time | PIV / EPIV number | Site | Number of attempts | Catheter gauge | Lot number | Patient / caregiver education provided | Initial |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | ☐ Verbal ☐ Written | |
| | | | | | | | ☐ Verbal ☐ Written | |
| | | | | | | | ☐ Verbal ☐ Written | |

✓ Check to indicate task completed or **N/A** if not applicable — **PN** – if further documentation in Progress Notes

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Date** | | | | | | | | | | | | | | | |
| **Shift** | | **D** | **N** | **D** | **N** | **D** | **N** | **D** | **N** | **D** | **N** | **D** | **N** | **D** | **N** |
| **Time** | | | | | | | | | | | | | | | |
| **Daily review of need for PIV / EPIV** | | | | | | | | | | | | | | | |
| **Patient experience acknowledged** (see reverse) | | | | | | | | | | | | | | | |
| **Patency assessment** (and correct line placement confirmed) | | | | | | | | | | | | | | | |
| **Site assessment** (see reverse for scales and frequency) | **Infiltration scale** | | | | | | | | | | | | | | |
| | **Phlebitis scale** | | | | | | | | | | | | | | |
| **Arm circumference** (cm) (*EPIV only, see reverse) | | | | | | | | | | | | | | | |
| **Dressing dry and intact** | | | | | | | | | | | | | | | |
| **Dressing change** | last changed: _____ | | | | | | | | | | | | | | |
| **IV cap change** | last changed: _____ | | | | | | | | | | | | | | |
| **Tubing change** (see reverse) | last changed: _____ | | | | | | | | | | | | | | |
| **FLUSH** Sterile **NORMAL SALINE 0.9%** 3 mL ****FLUSH** EPIVs with **NORMAL SALINE 0.9%** **Adults** 10 mL before access and 10 to 20 mL after access. **Pediatrics** 5 mL before each access and 5 to 10 mL after each access | | | | | | | | | | | | | | | |
| **Initial** | | | | | | | | | | | | | | | |

| Complications | Date (dd/mm/yyyy) | Initial |
|---|---|---|
| Catheter damage | | |
| Catheter embolism | | |
| Catheter-related bloodstream infection | | |
| Infiltration / extravasation | | |
| Nerve injury | | |
| Phlebitis | | |
| Site infection | | |
| Skin impairment (CASI) | | |

| Removal | Date (dd/mm/yyyy) | Initial |
|---|---|---|
| Removed intact | | |
| Reason for removal: | | |

# REGIONAL PERIPHERAL IV (PIV) & EXTENDED DWELL PIV (EPIV) INSERTION & MAINTENANCE RECORD



| Peripheral IV Therapy Guideline Resources (for more details see, IV Therapy – Clinical Practice Manual) | |
|---|---|
| **1. Patient and family education and experience** | Patient, caregiver and nurse conversation acknowledging process, treatment, and overall subjective experience (e.g., confidence and understanding of why IV needed, insertion process, IV site assessment, and when to report complications). |
| **2. Flushing** | **PIVs (and EPIVs) after each access and a minimum of Q12H in Acute Care, Long-Term Care settings. Q24H in outpatient, community settings.** Between incompatible medications, after blood draws, after blood or blood product transfusions, after injection of contrast media, or when locking the PIV. **Flush solution:** Sterile **NORMAL SALINE 0.9%** 3 mL using 5 mL pre-filled syringe **Flush / lock extended dwell PIVs with 10 mL **NORMAL SALINE 0.9%** before each access and 10 to 20 mL **NORMAL SALINE 0.9%** after each access using a 10 mL pre-filled syringe. Flush Pediatric EPIV with 5 mL **NORMAL SALINE 0.9%** before each access and 5 to 10 mL **NORMAL SALINE 0.9%** after each access. ***Exception:*** *In patients who have demonstrated high occlusion rates, despite increased flushing frequency and volume, the RN may opt to lock the PIV with 1 to 3 mL of HEPARIN 10 units/mL.* |
| **3. Site assessment** | **1. At least every 4 hours:** Patients who are receiving non-irritant/ non-vesicant infusions, who are alert and oriented and who are able to notify the nurse of any signs of problems such as pain, swelling, or redness at the site.<br>**2. At least every 1 to 2 hours:** Critically ill patients. Adult patients who have cognitive/ sensory deficits or who are receiving sedative-type medications and are unable to notify the nurse of any symptoms, or PIVs placed in a high-risk location (e.g., external jugular, area of flexion).<br>**3. At least every hour:** Neonatal patients and Pediatric patients<br>**4. At least every 30 minutes:** Peripherally administered vesicants<br>**5. More frequently every 6 to 10 minutes:** For solution and/or medication with increased clinical risk. Patients receiving intermittent infusions of chemotherapeutic vesicants and infusions of vasoconstrictor agents.<br>***EPIVs:** Measure arm circumference daily if arm is increasing in size with discomfort (mark measurement place on arm). |
| **4. IV cap / extension set change** | Every 7 days with dressing change, if removed, contaminated, damaged, and PRN |
| **5. Infusion set (tubing) changes** *always label tubing for next change date* | **Continuous infusions:** primary administration sets and secondary administration sets that are attached: Q7 days and PRN.<br>**Intermittent infusions:** includes primary and secondary sets not attached to patient continuously: After each use, when contaminated, or to a maximum of Q24H.<br>**Blood:** After 4 hours or 4 units of PRBC. See Blood Guideline for details.<br>**Parenteral Nutrition:** For infusions containing amino acids/dextrose, Q24H.<br>**Infusions containing lipid emulsion:** With each dose or a minimum of Q12H. |
| **6. General considerations** | **TKVO (To Keep Vein Open) or TKO (To Keep Open)** will be considered an acceptable order and will be defined as 1 to 50 mL/h |

**INFILTRATION SCALE** ****adapted from (Amjad, Murphy, Nylander-Housholder, & Ranft, 2011) (Infusion Nurses Society, 2011) (Simona Pop, 2012)*

| Grade | Clinical Criteria | Action |
|---|---|---|
| 0 | No symptoms | No action |
| +1 | Skin blanched, edema less than 3 cm in any direction or 1 % to 10% of the extremity above or below the insertion site, cool to touch, with or without pain | Discontinue infusion, remove PIV and re-site if necessary on opposite arm |
| +2 | Skin blanched, edema 3 to 15 cm in any direction or up to ¼ of the extremity above or below the insertion site or 10% to 25% of the extremity above or below the insertion site, cool to touch, with or without pain | Discontinue infusion, remove PIV and re-site if necessary on opposite arm, apply warm dry heat to infiltration site for 20 min periods, 3 to 4 times per day to alleviate discomfort and help absorb infiltration. |
| +3 | Skin blanched, translucent, gross edema greater than 15 cm in any direction or ¼ to ½ of the extremity above or below the insertion site or 25% to 50% of the extremity above or below the insertion site, cool to touch, mild to moderate pain, possible numbness | Discontinue infusion; determine type, concentration, and volume of solution infused. **Notify MRP.** Discontinue infusion, remove PIV and re-site if necessary on opposite arm, apply warm dry heat to infiltration site for 20 min periods, 3 to 4 times per day to alleviate discomfort and help absorb infiltration. |
| +4 | Skin blanched, translucent; skin tight, leaking; skin discoloured, bruised, swollen; gross edema greater than 15 cm in any direction or greater than ½ of the extremity above or below the insertion site or greater than 50% of the extremity above or below the insertion site; deep pitting edema; circulatory impairment; moderate to severe pain; infiltration of any amount of blood product, irritant, or vesicant. ******EXTRAVASATION IS ALWAYS GRADED AS +4*** | Discontinue infusion; determine type, concentration, and volume of solution infused. **Notify MRP.** Follow instruction in IV Therapy – Clinical Practice Manual for treatment **before removing IV cannula** (see also "Potential Hazards of Administration" in PDTM drug monograph) **Consider referral Plastic Surgery **Complete PSLS**** |

**PHELBITIS SCALE** ****adapted from the Infusion Nurses Society, 2011*

| Grade | Clinical Criteria | Action |
|---|---|---|
| 0 | No symptoms | No action |
| +1 | Redness at insertion site with or without pain | Observe, remove PIV and re-site if necessary |
| +2 | Pain at insertion site with redness and/or edema | Remove PIV and re-site if necessary on opposite arm, **notify MRP** if patient febrile |
| +3 | Pain at insertion site with redness, streak formation, palpable venous cord | Remove PIV and re-site if necessary on opposite arm, **notify MRP,** apply warm dry heat to phlebitis site for 20 min periods, 3 to 4 times per day |
| +4 | Pain at insertion site with redness, streak formation, palpable venous cord greater than 3 cm in length, purulent drainage | Remove PIV and re-site if necessary on opposite arm, **notify MRP,** apply warm dry heat to phlebitis site for 20 min periods, 3 to 4 times per day, if purulent drainage present, collect swab and send for C&S. |