

Cross Site Vascular Access and IV Therapy Clinical Guidelines

Part 7: Short Term Non-Tunnelled Central Venous Catheter

Key Points

- Short term non-tunnelled central venous catheters (STN-CVC) are sometimes referred to as Acute CVC and can be cared for and used for any IV therapy administration on any clinical area however they are generally used by critical care.
- The insertion, care and maintenance is covered by this guideline, the vascular access LocSSIP and the infection prevent and control manual.

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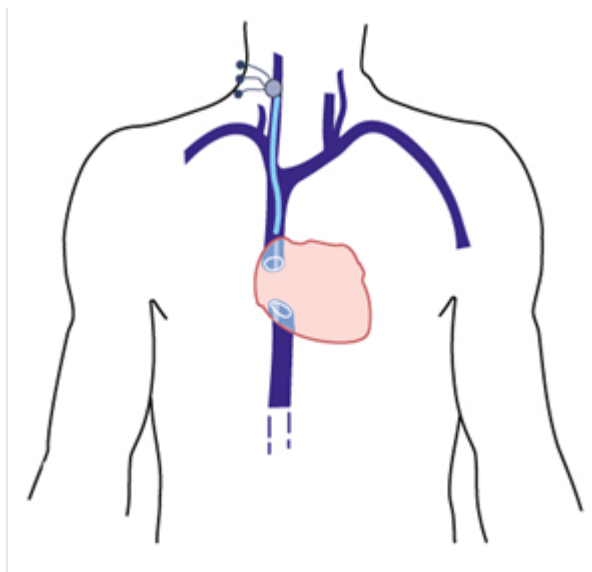
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Abbreviations

ACF	Antecubital Fossa
ANTT	Aseptic Non-Touch Technique
COPD	Chronic Obstructive Pulmonary Disease
CRBSI	Catheter Related Blood Stream Infection
CVC	Central Venous Catheter
ECG	Electrocardiogram
GI	Gastrointestinal
IV	Intravenous
IVAS	Intravenous and Vascular Access Services
LocSSIP	Local Safety Standards
MC&S	Microscopic Culture and Sensitivity
NICE	National Institute for Health and Care Excellence
NIVAS	National Infusion and Vascular Access Society
NST	Nutritional Support Team
OPAT	Outpatient Parenteral Antibiotic Therapy
PICC	Peripherally Inserted Central Catheter
PN	Parenteral Nutrition
PSA	Procedural Sedation and Analgesia
PVC	Peripheral Venous Catheter
RIVC	Renal IV Catheter
SPN	Supplemental Nutrition
STA-CVC	Short Term Acute Central Venous Catheter
TCCVC	Tunnelled Cuffed Central Venous Catheter
TIIP	Totally implanted Intravenous Port
TPN	Total Parenteral Nutrition
VA	Vascular Access
VAD	Vascular Access Device
VasCath	Vascular Catheter

1. SHORT TERM NON-TUNNELLED CENTRAL VENOUS CATHETER



Short Term Non-Tunnelled Central Venous Catheters (SNT-CVC) are predominantly used in critical care areas and theatres to administer multiple intravenous therapies and vesicants and are usually indwelling for up to 10 days to minimise the risk of infection although the catheters are licensed to indwell for up to 29 days.

Patients in any clinical area can have a STA-CVC if clinically indicated, all staff are trained to care for and use an acute SNT-CVC during the Trust IV study day. When a patient has an SNT-CVC in a non-critical care area a vascular access team referral should be made so it can be replaced with a more suitable device as soon as possible. *SNT-CVC* are most used in general clinical units for IVDU patients or those with unavailable peripheral veins.

The Primary SNT-CVC Insertion site is the neck internal jugular followed by the axillary vein and then the subclavian vein, with the femoral vein as the last resort. All these sites are susceptible to infection and other complications. The femoral catheter is most susceptible to infection and should be avoided. If a femoral catheter is inserted, it should be replaced as soon as possible.

- The Vascular Access LoCSSIP (Part2) should be followed when inserting any Central Venous Catheter.
- Where possible, written consent must be obtained from the patient and complications associated with the insertion of SNT-CVC explained to them; this must include guidewire retention risk and pneumothorax. This may not be possible in an emergency or if the patient is unconscious, in which case the responsible consultant must consent to the insertion.
- During the procedure the removal of the guidewire must be acknowledged and witnessed; and at the end of the procedure all sharps and the guidewire must be accounted for, the wire disposal must be witnessed and documented.

- Critical Care have developed a local policy for the insertion, care and maintenance of SNT-CVC. The basis of that guideline is in line with this trust wide organisational guideline. The trust wide guidance should be the primary policy for all aspects of SNT-CVC.
- SNT-CVCs should be inserted with prevention of infection, staffing numbers, the general location within the hospital and expertise issues in mind. The Trust Standard CVC pack should be used in all locations; these will be kept in the areas specified below. Areas able to meet all relevant criteria when inserting a SNT-CVC:
 - Theatres
 - Critical Care
 - Coronary Care Unit
 - MADU
 - ED Resuscitation
 - Interventional Radiology
 - Renal Unit
 - IVAS unit
- In the case of an emergency (e.g., cardiac arrest) the insertion may be undertaken on the general ward; however, the line should be considered as “dirty” and be changed within 24hrs. In cardiac arrest, the preferred central access is interosseous.
- The number of catheter lumens should be considered carefully to minimise complications, but to meet clinical need. The least number of lumens used the more effective in reducing complications. (Loveday HP, Wilson JA, Prieto J, Wilcox M 2015)
- The insertion of SNT-CVC devices is undertaken by limited groups of clinicians, usually in Critical Care, Emergency Department and the Vascular Access team, this is outlined in the Vascular Access LoCSSIP (part 2).
- It is the responsibility of the Vascular Access team to lead on the selection of Catheters and other consumables in relation to SNT-CVCs, including insertion packs; and to ensure that the needs of all hospital sites and teams’ insertion of SNT-CVCs are considered, and standardisation is achieved.
- Within the insertion pack is a documentation sticker which is to be scanned into the patients Epic EPR to enable monitoring and audit.
- Contents of Pack.
 - 2% Chlorhexidine in Alcohol (Chloraprep 3mls).
 - Large sterile top drape and under drape
 - Sterile gauze
 - Scalpel
 - Sterile gown and hat
 - Transparent dressing (Tegaderm IV®)
 - Syringes, blunt filter needle and orange needle.
 - Fixation device (suture or adhesive device)
 - Documentation sticker.
 - Audit form.

2. INSERTION OF THE CATHETER

- Insertion of SNT-CVCs should be made using full surgical ANTT using drapes, gowns, etc., as outlined in the vascular access LocSSIP (Part 2 of this set of guidelines).
- Ultrasound guided cannulation of the central veins is the gold standard approach and supported by the RCN, Epic3, the INS and the Royal College of Anaesthetists guidelines for safe vascular access 2016.
- Care should be taken to ensure that sterility is maintained, the ultrasound probe must remain sterile, even when undertaking the vein assessment prior to the procedure, this is in line with DoH safe use of ultrasound gel guidelines.
- Resuscitation equipment should be available in the locations where SNT-CVCs are inserted.
- Experienced nursing staff should be immediately available during the insertion of SNT-CVCs
- Details of the procedure with the potential risks and complications should be discussed with the patient and verbal consent from the conscious patient should be obtained prior to the procedure and documented in the notes.
- If possible, ensure patients have had a recent FBC (to check platelets) and INR (to check coagulation).
- Preferred site for the insertion should be determined. This is usually internal jugular vein, followed by subclavian vein or femoral vein, but this order could change, according to a clinical situation. N.B. Operator should be aware of the contraindications for subclavian vein catheterisation and increased infection risk associated with femoral insertion and the site must be chosen appropriately.
- Local anaesthetic and/or sedation should be used whenever possible.
- Insertion is to be undertaken using an aseptic technique and maximal sterile precautions. If hair removal is required, it should be accomplished using clippers rather than razors (INS 2024).
- Clean site with 10mls or 3mls Chlorhexidine 2% in 70% alcohol and allows it to dry (e.g., Chloraprep® using cross hatch technique). Orange tinted Chloraprep® can also be used. If there is sensitivity to Chlorhexidine solution single-use Povidone applicators must be used (Pratt et al 2007).
- CVC should be inserted using Seldinger technique with the patient lying flat.
- The catheter is primed with 0.9% sodium chloride prior to insertion and on insertion aspirated and re-flushed with 0.9% sodium chloride. This should clear all blood contamination in the lumen, prevent blockage and reduce risk of infection.
- The tip of the catheter should be at or below the level of carina, no further than the cavo-atrial junction (not for femoral vein catheterisation).

- A 20cm catheter can be used for a left sided approach and a 16cm catheter for a right sided.
- Suturing the catheter in place on the neck can increase the risk of infection; if possible, an adhesive fixation device can be used.
- Tissue adhesive can be used to seal and secure the exit site of the catheter to reduce exit site bleeding.
- Skin should be cleaned of all blood.
- A single clear semi permeable dressing (Tegaderm CVC dressing) should be applied to the dry skin surrounding the catheter exit site.
- Details of the insertion should be documented in the patient's notes using the special sticker.
- The patient can be positioned as per personal preference and clinical need once the line is secured with a dressing, and the area is made safe for other practitioners.

3. POST PROCEDURE

- Until the position of the catheter tip is confirmed, preferably by the operator Registrar and above or the IVAS lead, the catheter should not be used
- Every patient should have a chest X-ray post SNT-CVC insertion even if the attempts failed and it should be assessed by the operator or handed over to a named doctor (not for femoral vein catheterisation)
- The tip of the catheter should sit past the carina in the SVC around the 3rd intercostal space
- 2 other confirmatory checks should be used to confirm catheter placement.

4. CONFIRMING CVC TIP PLACEMENT

✓ **Chest X-ray**

And

✓ **Venous Blood Gas**

✓ **Central Venous Pressure wave form**

Gabel,
for calculating and
acid-base
Physiology 42: pp.

**To
the tip is
SVC the
gas**

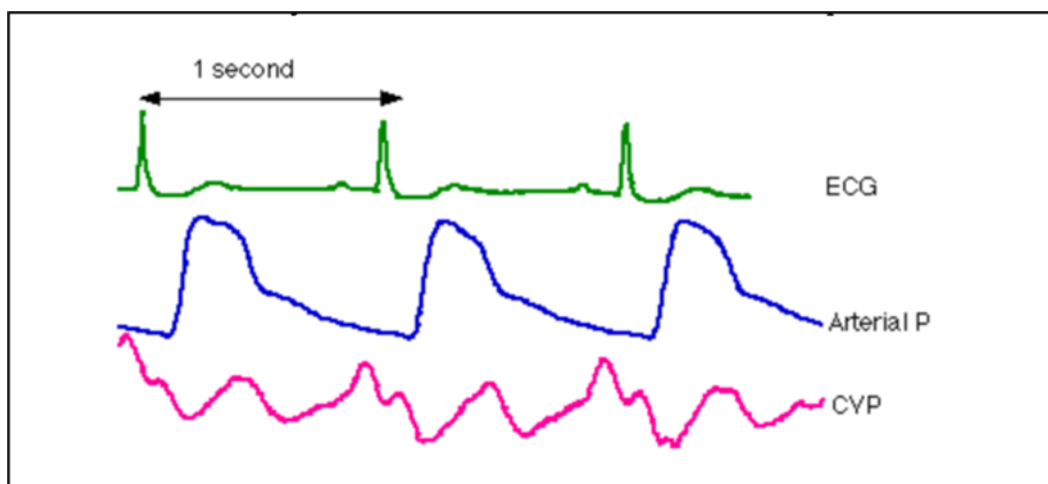
Element	Arterial Range	Venous Range
pH	7.35-7.45	7.33-7.42
PaO ₂	10.5 –13.5 kPa	5.5 – 6kPa
SaO ₂	>94%	<80%
PaCO ₂	4.7 –6.0 kPa	5.6 – 6.7 kPa
HC0 ₃	22 to 26 mEq/L	21 to 25 mEq/L

RA (1980) Algorithms
correcting blood-gas
variables. Respiration
211-232

**confirm
in the
blood
values**

should be in the venous range. Values in the arterial range would indicate the tip is in an artery.

Central Venous Pressure wave form



- To confirm the tip is in the SVC, a CVP reading waveform should be seen on the monitor. If the wave form is arterial, the catheter tip is in an artery.
- If arterial puncture is suspected **leave the catheter in place** and urgently discuss with the vascular surgical team and or interventional radiology. The patient will require emergency CT chest and neck scan before removal, the vascular team or interventional radiologists may need to remove the catheter in theatres. There may be thrombosis or uncontrolled bleeding which could be life threatening.
- SNT-CVCs should not be advanced or re-wired at any stage after initial insertion.
- SNT-CVCs should be removed in case of inflammation at the insertion site or unexplained pyrexia/sepsis; patient blood cultures should be taken (i.e., simultaneous catheter-*each lumen* plus peripheral blood cultures).
- SNT-CVCs are not changed routinely if there are no signs of local inflammation or sepsis.
- Lines with a blocked lumen should be replaced if appropriate techniques have failed to resolve the problem.
- IV infusions should never be disconnected after setting up. Disconnecting and reconnecting IV lines increases the risk of introducing bacteria or other pathogens into the bloodstream, potentially leading to serious infections.
- After any catheter's removal, the tip should be sent for microbiological investigation if an infection is suspected.
- A leaking catheter should be removed and replaced at a separate site.
- Once the SNT-CVC is no longer necessary it should be removed to avoid infection. The continuous necessity for SNT-CVC should be reviewed at every ward round and documented and a more appropriate alternative discussed

5. FLUSH TECHNIQUE

All lumens of the SNT-CVC should be flushed every 6 hours when the care bundle (see section 8, below) and VIP assessment (which is on the care bundle) is undertaken. Flushing the catheter regularly will increase the length of patency and reduce the risk of complications.

- The flush should be made using ANTT.
- The flush should be a 10ml flush of 0.9% sodium chloride.
- The date of the saline flush should be checked by another nurse.
- Use the push pause positive pressure technique to flush.
- Only 10ml or above syringes should be used.

6. DRESSING THE SNT-CVC

- A semipermeable single film, IV dressing should be used to cover the insertion point of the SNT-CVC
- It is important dressings remain clean and dry; they should be changed if they are loose, dirty or have fluid collecting under them.
- The dressing should be dated with the insertion date of the SNT-CVC, if the dressing is changed the insertion date of the SNT-CVC should be documented on the new film dressing.

SNT-CVC adhesive securement: Griplik CVC





Applying a dressing to a neck CVC



1 Prepare the site according to your facility's protocol. Allow all preps and skin protectants to dry completely. Open package and remove sterile dressing.



2 Remove liner to expose adhesive. Place dressing adhesive side up on sterile field or inside of dressing package.



3 Position notch edge of dressing over catheter hub, placing stabilization border over catheter "wings." Do not stretch dressing over skin surface.



4 Apply dressing to skin applying firm, gentle pressure to window film. Pinch film firmly around catheter tubing connection. Gently lift tubing connection and press border firmly under catheter lumens.



5 Slowly peel frame away from border edge while simultaneously applying firm pressure to border edge. Smooth entire dressing into skin to ensure optimal adhesion.



6 Remove securement tape strip with notch from liner. **Two small adhesive free tabs from liner will remain on tape strip liner.** Partially fold securement tape strip in half at notch.



7 Apply tape strip's pre-cut notch completely underneath catheter's molded junction. The notch opening should face the insertion site. Peel paper tabs from liner corners. Smooth entire dressing surface; working from catheter insertion site out toward dressing edge.



8 Prepare and apply documentation label over the top of the exposed molded junction. Press first half of strip against the junction; then adhere the other side.



9 Apply firm pressure to entire dressing to ensure optimal adhesion.

1685 Removal Technique



1 Remove all securement tape strips from dressing.



2 Gently grasp soft cloth edges below keyhole notch.



3 Lift dressing on each side from skin using low and slow technique.



4 Peel dressing toward catheter insertion site until removed.

DOCUMENTATION OF THE SNT-CVC

Avatar

Back CVC Triple Lumen Right Internal jugular

Properties

Responsible: Resign

Placement Date: Placement Time:

Placed by External Staff? ☐ Clinic ☐ Other hospital ☐ Radiology ☐ Other (Comment)

Consent: ☐ Written ☐ Verbal ☐ Best Interest ☐ Implied

Insertion Reason:

Hand Hygiene Completed: ☐ Yes ☐ No - please comment

Is the patient at risk for Medical adhesive-related skin injuries (MARS)? ☐ Yes ☐ No

Site Prep: ☐ Alcohol/Chlorhexidine ☐ Betadine ☐ Other (Comment)

Site prep agent has completely dried before insertion? ☐ Yes

All 5 sterile barriers used (Gloves, Gown, Cap, Mask, Large Sterile Drape)? ☐ Yes ☐ No

Local Anaesthetic (refer to MAR): ☐ Injectable ☐ Sedation ☐ None

Catheter Type: ☐ 18 cm ☐ 24 cm ☐ Other (Comment)

View back

Avatar

Back CVC Triple Lumen Right Internal jugular

Assessment

Time taken: 24/3/2025 10:05 Responsible: Resign Create Note Macro Manager

Orientation: Right Site: Internal jugular

Reason for Line Necessity:

VIP Score: 0 1

VIP Assessment: ☐ No signs of phlebitis ☐ Discharge ☐ Pain ☐ Redness ☐ Swelling ☐ Other (Comment)

Number of days in place: ☐ Day 1 ☐ Day 2 ☐ Day 3 ☐ Day 4 ☐ Day 5 ☐ Day 6 ☐ Day 7 ☐ Day 8 ☐ Day 9 ☐ Day 10 - to be removed

Catheter Status: ☐ Capped ☐ Occluded ☐ Flushed ☐ Infusing ☐ Leaking around... ☐ Positional ☐ Other (Comment)

Length mark (cm):

Securement Type: ☐ Griplock ☐ Sutured ☐ Transparent dressing ☐ Other (Comment)

Dressing Status: ☐ Clean ☐ Dry ☐ Intact ☐ With transparent film dressing ☐ With insertion date on dressing

Dressing changed (Comment):

Dressing Type: ☐ CHG dressing ☐ Silicone dressing ☐ Transparent dressing ☐ Other (Comment)

Exit Site Protection: ☐ Skin barrier ☐ Other (Comment) ☐ N/A

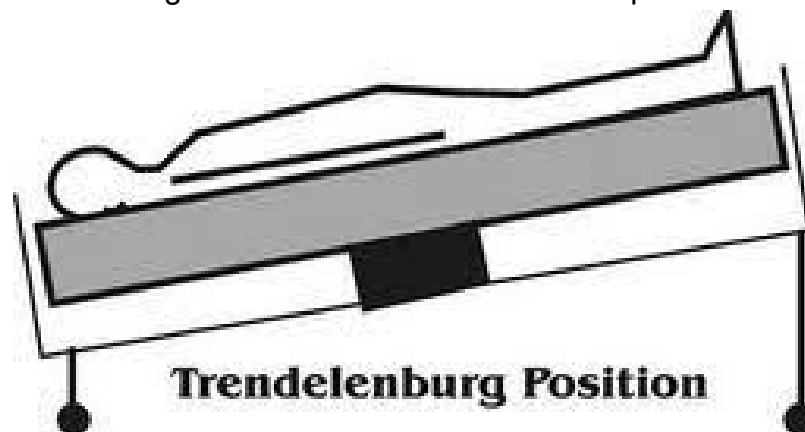
View back

A SNT-CVC insertion record must be completed and filled in the patients record and a procedural note will need to be completed. Assessment of the device is to be completed on the patients Epic LDA avatar a minimum of 3 times daily and a documented VIP of 0 for each use.

9. SNT-CVC REMOVAL (NECK AND FEMORAL)

IF THERE IS PULSATILE BLOOD VISIBLE IN THE LUMEN OF THE SNT-CVC, IF ARTERIAL PUNCTURE SUSPECTED **DO NOT REMOVE DEVICE** – CALL FOR EMERGENCY/SPECIALIST HELP (VASCULAR TEAM, IR TEAM, IVAS TEAM)

- Removal of the SNT-CVC must be undertaken by a competent healthcare professional.
- Removal should be undertaken routinely, if the maximum indwell time has been reached or the line is showing signs of infection.
- Discussion should take place with the team or expert who has inserted the line if complications develop, in order to prevent the unnecessary removal of the line; however, this should not delay the removal if the line is causing harm, i.e., infection.
- An awareness of the patient's coagulation status is required.
- When removing a central venous catheter, the patient's INR should be reviewed, and the procedure should not go ahead unless the INR is therapeutic.



- Blades and scalpels should not be used to cut anchoring sutures as this may fracture the catheter – sterile scissors or a stitch cutter should be used
- For removal of CVC lines from the Internal Jugular or Subclavian vein, the patient **MUST** be placed in the Trendelenburg position and the patient must perform the Valsalva manoeuvre prior to/during the removal.
- Valsalva Manoeuvre
The Valsalva manoeuvre is performed by moderately forceful attempted exhalation against a closed airway, usually done by closing one's mouth, pinching one's nose shut while pressing out as if blowing up a balloon
- Following removal, appropriate amounts of pressure should be used over the insertion site to ensure bleeding has not occurred (MINIMUM OF 3 MINUTES)
- The procedure should be carried out using an aseptic non-touch technique. Tips should **ONLY** be sent for MC&S if infection is suspected, as per microbiology protocols.
- The removal needs to be recorded in the patient's record

- Once the bleeding has subsided with pressure, an occlusive gauze and film dressing should be applied and the area monitored for haematoma formation.
- **The patient MUST be flat during and after removal to avoid air embolism (30mins)**

If an Air Embolism is suspected at any time while the patient has a central or arterial catheter in place or after removal – Call for help 2222 NEWS call

- **Place the patient in the Trendelenburg position**
- **Trendelenburg position:** Lying the patient on their back so the feet are elevated 15 to 30 degrees above their head.
- **Left lateral decubitus:** lying on the left side in an effort to trap the air next to the right ventricular apex; this prevents or minimizes the obstruction of the pulmonary artery. The patient will also receive a high oxygen percentage gas mix (McCarthy C. J. *et al.* (2016))

10. COMPLICATIONS ASSOCIATED WITH SNT-CVC

Complication	Device affected	Definition	Symptoms	Prevention	Treatment
Phlebitis	All	Inflammation of either the intima or all 3 layers of the vein. Three types: Mechanical, Chemical & Bacterial.	Pain.	Phlebitis	All
Infection	All	The acute inflammation of the vein	Redness, Swelling, Exudate at the entry site. Palpable cord Pyrexia especially if associated with line flushing.	Hand cleaning. Aseptic or non-touch technique. Use of skin preparation. Minimise manipulation of system. Maintenance of closed system. Maintaining sterility of items.	Report Symptoms, MC&S swab exudates. Send catheter tip for MC&S <i>NB Rigors associated with flushing of line should be treated as an emergency</i>
Anaphylaxis	All	An allergic type reaction most commonly precipitated by the injection of a foreign substance.	Rash. Redness. Shortness of breath. Itchiness.	Check allergy bands.	Dependant on the severity. If life threatening call for help and give IM adrenaline 1:1000 - 500microgram IM injection – Follow UK Resuscitation council guidelines
Speed shock	All	The rapid administration of a fluid.	Facial flushing Dizziness. Headache.	Administer medication/fluid at the recommended speed.	Call for help Inform clinical team ABCDE assessment.
Extravasation	All	The inadvertent administration of a vesicant solution into the surrounding tissues.	Erythema, pain and swelling around device and in limb, blistering, dark skin discoloration	Avoid peripheral injection of vesicants – use central IV access.	Treatment should be dependent on the pharmaceutical manufacturer's guidelines the properties of the extravasated agent and the severity of the extravasation.
Thrombosis	Mainly associated with PICC and tunnelled lines.	Formation of blood clot in the vein.	One sided dark swollen, mottled area in shoulder, neck or upper body area. Obvious Collateral veins on one side of upper body.	Warfarin therapy. The smaller the device the better.	Inform Vascular Access team, ultrasound the affected arm and leave PICC in situ. Commence low molecular weight heparin - discuss with Vascular team. PICC can be removed following expert guidance.
Mal position	All.	By clinical evidence and imaging techniques.	Potentially none, other than imaging findings. Otherwise: arrhythmias, pain or poor infusion.	Correct positioning of the patient and correct use of equipment and techniques.	Clinical manoeuvres. Semi- withdrawal and re-insertion (if sterile field still intact). Remove and further attempt with new line and/or site.

Splitting / reporting	All	Blood, line content evident around the line. On aspiration of line lack of pressure and air bubbles evident.		Avoid poor flush technique. Avoid using syringes less than 10 ml	Seek expert advice from interventional radiology or vascular access team prior to removing.
Blockage	All	Blockage or kinking of the line	Inability to administer sodium chloride 0.9% through the line.	Flush well before, between and after all drugs. Flush using the push-pause, positive pressure technique. Flush device as per protocol if not in use.	DO NOT use anything smaller than a 10ml syringe. See guidelines for persistent withdrawal occlusion (appendix 1).
Failure to place	All.	By clinical evidence and imaging techniques.	Failure to cannulate the vessel or ascend/descend the line to final destination.	Appropriate positioning of patient. Appropriate choice of line. Expert or supervised clinician. Utilisation of USS guidance. Alternative insertion site	Discuss with senior clinician, team and patient. Escalate to vascular access team.
Haematoma	All	Uncontrolled bleeding at vessel puncture site	Bleeding, swelling at insertion site	Release tourniquet at appropriate time, check clotting range and apply 2 to 3 mins pressure after removal	Apply pressure to haematoma site if new, elevate limb and inform clinical team. Consider Vascular Surgeon opinion if severe
Arterial Puncture	All	During insertion the needle transfixes the artery peripherally	Bleeding at insertion site, excessive bleeding via sheath during insertion, after insertion lines will be pulsatile and act against gravity	Where possible use ultrasound to insert catheter and/or avoid ACF and ensure vein is palpable and not pulsatile	Remove and apply at least 3mins of pressure, document and observe site for haematoma

Air Embolism	All CVC	Air in the venous system	Cyanosis, tachypnea, dyspnea, coughing, tachycardia and hypotension.	Maintain closed system Use clamps on open-ended line. Remove air from all drugs prior to IV administration.	Close system to air (clamp) Treat as an emergency, call for help 2222 Report to clinician. Put patient in the left Trendelenberg position (head down). Administer oxygen therapy via a non-rebreath mask.
Arterial Puncture	All	During insertion the needle transfixes the artery peripherally	Bleeding at insertion site, excessive bleeding via sheath during insertion, after insertion lines will be pulsatile and act against gravity	Where possible use ultrasound to insert catheter and/or avoid ACF and ensure vein is palpable and not pulsatile	Remove and apply at least 3mins of pressure, document and observe site for hematoma
Pneumothorax and/or haemothorax (only in the first 24 hours)	All CVCs	Punctured lung is a complication of insertion.	Shortness of breath +/- pain in the first 24 hours after insertion of line.	Consider choice of site carefully. Ensure high level of expertise or supervised practice is applied in order to minimise risks. Give careful consideration to CPAP, IPPV and emphysematous patients. Consider coagulopathy and thrombolytic therapies.	Treat as an emergency Call for help 2222 Emergency chest x-ray. Report to clinician and consider the need for a chest drain. Put patient in the left Trendelenberg position (head down). Administer oxygen therapy if available.
Acute CVC Tip in artery – carotid/aorta	All CVCs	During insertion the needle transfixes the internal jugular into the carotid artery	Bleeding at insertion site, excessive bleeding via sheath during insertion, after insertion CVC lines will be pulsatile and act against gravity e.g., backflow of blood, pump alarming high pressure etc.	Ultrasound guided insertion of neck CVC is recommended and tip confirmation must be by chest x-ray and either CVP wave form transducer or venous blood gas unless placed with fluoroscopy.	Vascular surgeons should be urgently consulted prior to the line being removed because of the risk of stroke caused by carotid arterial thrombus and/or uncontrolled bleeding/hematomas at insertion site and at arterial puncture site through underlying structures in the neck.

Reference

Loveday, H.P. *et al.* (2016) 'Epic3: revised recommendation for intravenous catheter and catheter site care', *Journal of Hospital Infection*, 92(4), pp. 346-348. Available at: <https://doi.org/10.1016/j.jhin.2015.11.011> (Accessed: 27 March 2025).

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McCarthy, C. J. *et al.* (2016) 'Air Embolism: Practical Tips for Prevention and Treatment', *Journal of Clinical Medicine*, 5(11), p. 93. Available at: <https://doi.org/10.3390/jcm5110093> (Accessed: 27 March 2025).

Full version control record

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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using guidelines after the review date. This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version Control Sheet

Version	Date	Guideline Lead(s)	Status	Comment
1	03/04/17	Advanced Nurse Practitioner Vascular Access	Final	
2	05.11.2019	Advanced Nurse Practitioner Vascular Access	Final	Ratified at NMB
3	May 2025	IVAS Nurse Consultant	Final	Scheduled review

Related Documents

Document Type	Document Name
Guideline	Part 1 Vascular Access Policy
Guideline	Part 2 Vascular Access LocSSIP
Guideline	Part 3 Peripheral Cannulation Guidelines
Guideline	Part 4 Venepuncture Guidelines
Guideline	Part 5 Midline Guidelines
Guideline	Part 6 PICCs
Guideline	Part 8 Implanted Port and Tunnelled Catheter Guidelines
Guideline	Part 9 Arterial Catheter Guidelines
Guideline	Part 10 Injectable Medicines Policy
Guideline	Part 11 Extravasation Guidelines
Guideline	Part 12 Long-term CVC Complication Guidelines
Guideline	Procedural Sedation and Analgesia guideline
Guideline	FHFT IPC Manual https://guidelines.fhft.nhs.uk/
Guideline	RCN Infusion Standards
Guideline	INS Infusion Standards
Guidance	Epic