

Trust Standard Operating Procedure

Standard Operating Procedure

Management of Peripheral Cannulae

Date	Version
November 2016	2

Purpose

- The purpose of this procedure is to ensure that peripheral cannulation insertion, on-going care and removal of cannulae is performed safely by competent healthcare practitioners thus eliminating the risk of complications as far as is reasonably practical.

Who should read this document?

This procedure must be adhered to by all Clinical Staff caring for patients who may require cannulation to administer intravenous medication and/or fluids and by all clinical staff before attempting removal of a peripheral cannula.

Key messages

Cannulation is an invasive procedure which carries associated risks. Cannulation therefore must only be performed where there is a clear clinical need by a competent Healthcare Practitioner or by an individual who has received training and is being supervised by a competent practitioner for assessment purposes.

Practitioners must adhere to the procedures outlined in this document during insertion, caring for indwelling cannulae, and on removal.

Standard aseptic non touch technique, single patient use equipment and cannula's that adhere to safer sharps principles must be used.

All aspects of cannulation management must be documented in patient records including the patient's prescription sheet for adult in-patients.

Cannula's must be removed as soon as possible: within 24hours if sited in an emergency situation, if VIP score is 2, or resited within 72hours.

Accountabilities

Production	Sarah Hockey Learning & Development Lead
Review and approval	Beverley Allingham Deputy Director of Nursing
Ratification	Nursing and Midwifery Committee (NMOC)
Dissemination	Trust wide
Compliance	Medical Devices Committee

Links to other policies and procedures

- Acute Care Team Adult lower limb Cannulation and Venepuncture Standard Operating Procedure Feb 2016
- Guidelines for aseptic technique Version 4 November 2012
- Hand Hygiene Policy 2015
- ANTT Peripheral Cannulation 2013
- Prevention of Contamination incidents 2012
- Management of Contamination incidents 2015
- Decontamination guidelines and procedures 2012
- Safe Handling and Disposal of Hospital Waste 2014

Version History

V1	December 2013	
V2	November 2016	
Last Approval		Due for Review
December 2016		December 2019

The Trust is committed to creating a fully inclusive and accessible service. By making equality and diversity an integral part of the business, it will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on the Trust Documents Network Share Folder (G:\TrustDocuments). Larger text, Braille and Audio versions can be made available upon request.

Standard Operating Procedures are designed to promote consistency in delivery, to the required quality standards, across the Trust. They should be regarded as a key element of the training provision for staff to help them to deliver their roles and responsibilities.

Section	Description	Page
1	Purpose and Scope	4&9
2	Definitions	4&9
3	Regulatory Background	4&9
4	Key Duties	4&9
5	Monitoring and Assurance	4&9
6	Procedure to Follow for insertion of Cannulae	5-8
7	Procedure to Follow for management of Cannulae	8
8	Procedure to Follow for removal of Cannulae	9-11
9	Document Ratification Process	11
10	Dissemination and Implementation	11
11	Reference Material	11-12
Appendices		
	Peripheral IV Cannula record sheet	13
	Competency for removal of Cannulae	14-16

Insertion and management of Peripheral Cannulation SOP

1 Purpose and Scope

Introduction

This Standard Operating Procedure is relevant to all Health Care Practitioners involved in peripheral cannulation.

Definitions

A peripheral cannulae is a flexible tube which is inserted into a blood vessel to give drugs or fluid to a patient (Anderson and Anderson 1995).

Regulatory background

The Health & Safety at Work Act 1974 states that *“an employer must make provision for securing the health, safety and welfare of persons at work and for protecting others against risks to health or safety in connection with the activities of persons at work.”* *“No person shall intentionally or recklessly interfere with or misuse anything provided in the interests of health, safety or welfare.”*

European Directive on Safer Sharps systems (Directive 2012/32/EU) states that *“sharps injuries in the healthcare sector must be prevented. Systems must be in place by 11th May 2013 which include the use of equipment with a safety protection mechanisms.”*

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 require employers to identify substances hazardous to health which include the risk of exposure to blood borne viruses. The risk of exposure is reduced by the use of safety engineered devices, safe systems of work and the provision of protective equipment.

Key Duties

Managers to request training for staff via Workforce and Organisational Development Admin Team (WODadmin), where there is a service need which will necessitate the individual delivering this aspect of care on a regular basis.

All staff are responsible for complying with this SOP and their line manager must monitor to confirm compliance.

Staff undertaking cannulation training must complete all aspects within 3 months.

Assessment of competence on an individual is undertaken by a Healthcare professional (Registered Practitioner or Band 3 HCSW who has completed an Assessors Award) who is competent in the skill and this is documented on assessment sheets provided by WOD. Copies of completed assessment forms are forwarded to WOD admin and the original stored in the individuals personal records.

Monitoring and assurance

Managers or their nominated deputy will monitor on going competence of staff in performing all aspects of this skill. This will include adherence to Standard ANTT principles, correct hand hygiene and the insertion and after care of the cannula. This will be reported via the Saving Lives audit for Cannula Care which is monitored by Infection Prevention and Control, Matrons and IPC Link Nurses. If shortfalls are identified Managers with the support of Matrons and Infection Prevention and Control will develop action plans to resolve.

2 Training

Requests for peripheral cannulation training

Non-medical Health Care Practitioners can apply for peripheral cannulation training where there is:

- An identified service need for the member of staff to develop competence in this skill as indicated on local skills maps.
- Demand for the individual to perform this skill on a regular basis to ensure competence is maintained.
- Documented support by the Line Manager on the individuals training application form and confirmation of the service need. (Application forms can be obtained from staffnet (Clinical Skills))
- Evidence that the member of staff has completed all elements of mandatory training.

Staff Groups permitted to apply for training are:

- Registered healthcare professionals
- Unregistered healthcare practitioners if educated to a NVQ level 2 or equivalent, or on consultation with the Learning and Development Facilitator and Ward Manager
- Medical Assistants

Healthcare Practitioners appointed from outside the Trust who regularly inserted peripheral cannulae in their last post, must do the following:

- Show their line manager evidence of their training and competence and provide evidence of recent updating in this skill
- Read the Plymouth Hospitals NHS Trust peripheral cannulation procedure and guidelines along with all relevant policies and complete PHNT cannulation e-learning
- Practice to be observed by an assessor, nominated by their Manager
- Complete and sign off the peripheral cannulation practical assessment form, a copy of this should be placed on the individual's personnel record.

Staff who are permitted to assess competence

Registered Healthcare Professionals, who have been assessed as competent in this skill and regularly deliver this skill may supervise and assess staff that have completed the training.

Unregistered Healthcare Practitioners may also undertake this activity if they have been assessed as competent in this skill, deliver this skill regularly and have completed the Observational Assessors Course. For more information, please contact a member of the WOD Admin team 32026.

Assessment of practice must be documented on Trust Cannulation practical assessment forms and once complete sent to WOD Admin team who will enter these details on Trust database.

3 Procedure to Follow

It is the responsibility of staff performing peripheral cannulation to ensure that patients understand the reason for the procedure and that the procedure involves minimum distress to the patient.

Infection control procedures must be adhered to, including the use of cannulae with incorporated safety protection mechanisms and the safe disposal of sharps as per Trust policy. Standard aseptic non touch technique must be adhered to throughout the procedure of insertion and any further manipulations of the cannulae.

Emergency cannulations where asepsis cannot be guaranteed must be indicated with a red dot on the dressing. This cannulae must be replaced within 24 hours.

Positive Identification of the patient must occur.

The insertion and removal of peripheral cannula must be documented on the patients prescription chart and in patient notes (appendix A) or in outpatient areas in the patients safety questionnaire which is then scanned into CRIS.

If peripheral cannulation is unsuccessful after 2 attempts the health care professional must request a more experienced health care practitioner to undertake the procedure.

Main step 1 Peripheral Cannulation Procedure

Site of Insertion:

Median Cubital veins should not be used where possible as these should be reserved for blood sampling. Lower limbs should not be used unless risk assessed and the practitioner has undertaken additional training and assessment of competence. Information is available from the Acute Care Team

Choice of Cannulae:

When selecting a cannulae, the size and condition of the vein and the patient's treatment regime should be considered. Generally the smallest size cannulae for the patient's treatment and vein size should be chosen.

Peripheral cannulae should be used if intravenous therapy is short term i.e. less than 72 hours or prior to insertion of a longer term device. If therapy is required for more than 72hours but less than 4 weeks a midline should be considered. If therapy is required for more than 4 weeks a PICC, Tunnelled Line or TIVAD should be considered. **NB** additional training and assessment of competence is required for insertion of longer term devices. Contact Acute Care Team for more information

Cannulae incorporating a safety engineered device e.g. Venflon Pro Safety must be used.

Stylets should never be re-inserted after the first cannulation attempt.

All equipment should be sterile for every cannulation attempt. Single use devices should never be reused.

To Improve Venous Access:

A disposable single patient use tourniquet should be used. This should be placed 8-10cm above the insertion point. Rubber gloves should not be used as these cannot be released quickly and can cause tissue damage.

- Lower the limb below heart level
- Applying a warm compress
- Opening and closing of the fist
- Massaging the area in one direction (excessive tapping is not recommended as this can cause pain and bruising).

Equipment required

Clinically clean tray containing prepared equipment and attached sharps bin with temporary closure across

Safety engineered Cannula(e) of correct gauge for use

Cannulation packs where available which contain the equipment listed below or where not available the practitioner will need to collect :

SEPP applicator (70% alcohol / 2% chlorhexidine)

Sterile cannulae dressing (IV3000)

5-10ml 0.9% Sodium Chloride for flushing (less volume for small children)

10ml syringe

Needleless connector e.g. VAD site

Gloves and aprons as required for standard precaution measures

Tourniquet

Procedure

1. Identify the patient and explain the procedure. Obtain informed consent. N.B if required apply local/topical prescribed anaesthetic in accordance with prescription and guidelines.
2. Collect appropriate equipment in clean tray
3. Wash and dry hands thoroughly
4. Put on gloves and apron
5. Apply the tourniquet and other methods of venous dilation, select the vein
6. Clean the area of the selected vein with SEPP applicator, using a back and forth motion for a minimum of 30 seconds and allow to dry thoroughly. Do not re-palpate the area once cleaned. Ensure patient has no allergies to product prior to use. **N.B** For neonates please consult the neonatal intensive care unit guidelines.
7. Remove the cannulae from packaging and inspect for any faults
8. Stabilise the vein by applying manual traction on the skin
9. Ensure the cannulae is in the bevel up position and placing the device over the vein, insert the device at the selected angle (10 – 30 degrees) according to the depth of the patient's vein
10. Wait for the first flashback to appear in the primary flashback chamber of the cannula
11. Level the device by decreasing the angle between the cannula and the skin and advance the cannula a few millimetres to ensure entry into the lumen of the vein
12. Withdraw the needle slightly and a second flashback should appear along the shaft of the cannula. **NEVER** attempt to reinsert the needle
13. Slowly advance the cannulae off the needle into the vein
14. Release the tourniquet and apply pressure to the vein above the cannula tip, remove the needle and place into the sharps bin (sterile gauze may be placed under the cannula to absorb any blood leakage). **DO NOT COVER END OF CANNULAE WITH FINGERTIP AT ANY STAGE AS THIS WILL CONTAMINATE CANNULAE.**
15. Attach a primed closed connector e.g. VADsite where clinically able or sterile bung if closed connector unavailable.
16. Apply sterile IV3000 dressing, tape should **NEVER** be used. Date and time to be written on labels provided and this to be adhered to dressing.
17. Flush with 0.9% Sodium Chloride to ensure patency, observing site for signs of swelling or leakage and ask patient if they feel any discomfort
18. Remove gloves and apron
19. Dispose of waste according to appropriate policy and clean tray
20. Wash hands with soap and water
21. Document date and time of insertion, lot number, flush, size / colour of cannulae, site, number of attempts and any complications / actions on prescription chart and patient's notes.

Main step 2 Maintenance of cannulae patency

If intravenous administration is intermittent, the cannulae needs to be flushed 8 – 12 hourly to maintain patency. Cannulae should also be flushed before and after administration of bolus drugs to confirm cannulae position and prevent possible interaction between drugs. 0.9% Sodium Chloride is the most common flushing solution; however this is not compatible with all drugs (See IV Medicines Administration Monographs in Trust documents, for more detail about specific drugs).

The amount of flush required depends on the size of the cannulae, the patient and why it is to be used. In general terms, it is recommended that 5ml flush for smaller cannulae; 10ml flush for larger ones. Always use a 10ml syringe.

All flushes **MUST** be prescribed and checked by 2 Registered Healthcare Professionals or a Registered Healthcare Professional with an Assistant Practitioner who has been assessed as competent in intravenous administration. This must occur before administering, and the prescription chart **MUST** be signed.

Heparin flushes are not required for peripheral cannulae.

The rate of administering the flush should be the same as the preceding drug. The initial flush should be administered using a 10ml syringe, regardless of the volume of the flush. This exerts less pressure on the cannulae and the vein. Subsequent flushes and medication should be administered using a 10ml syringe wherever possible.

Unregistered staff e.g. HCA's, MA's who have received formal training and have been assessed as competent in peripheral cannulation are permitted to administer up to 10ml 0.9% Sodium Chloride to confirm patency of the cannula on initial insertion only. The flush **MUST** be prescribed and checked with a Registered Healthcare Professional who is competent in IV drug administration. Unregistered staff must not undertake subsequent flushing of the cannula unless they are Assistant Practitioners who have received additional training and assessment of competence and this is agreed in local protocols developed by pharmacy.

Main step 3

Ongoing Care of peripheral cannulae

Peripheral cannulae provide a means of access to the patients vascular system for the administration of medication and fluids. In addition it also provides a potential route for micro-organisms to enter the vascular system. Cannulae must therefore only be inserted if there is a clinical need and removed as soon as this need is eliminated. Cannulae that are clinically required for more than 72hrs or have been inserted in an emergency situation (indicated by red dot on dressing) must be resited. Whilst insitu an evaluation of the cannulae entry site should be documented each time the cannulae is accessed in accordance with the Guidelines for the Management of Peripheral Intravenous Devices 2013.

Where it is not possible to resite a cannulae required for more than 72hrs a risk assessment must be documented in the clinical notes and this must be reviewed on at least a daily basis.

Record keeping

Insertion of peripheral cannulae must be fully documented by the Health Care Practitioner who has undertaken this procedure on the patients Prescription sheet/clinical records (see appendix A).

Removal of a Peripheral Cannulae SOP

1 Purpose and Scope

Introduction

This SOP identifies staff permitted to perform this skill, the procedure they must adhere to and useful guidance for removing a peripheral cannulae.

Definitions

A peripheral cannulae is a flexible tube which is inserted into a blood vessel to give drugs or fluid to a patient (Anderson and Anderson 1995).

Regulatory background

The Control of Substances Hazardous to Health (COSHH) Regulations 2002 require employers to identify substances hazardous to health which include the risk of exposure to blood borne viruses. The risk of exposure is reduced by the use of safe systems of work and the provision of protective equipment.

Key Duties

Removal of peripheral cannulae should only be carried out by staff who have been appropriately trained and assessed as competent in this skill (**Appendix B**)

Staff developing competence must be directly supervised by a member of staff who is competent in the skill.

Positive Identification of the patient must occur before commencing the procedure.

It is the responsibility of staff performing Removal of Peripheral Cannulae to ensure that patients understand the reason for the procedure and that the procedure involves minimum distress to the patient.

Infection Control practices must be adhered to according to Trust policy. A sterile dressing must be placed onto the wound once the cannulae is removed.

The removal of peripheral cannulae must be documented on the patients prescription chart (**Appendix A**) and in patient notes or in Paediatric settings in part B of the admission notes

Monitoring and assurance

Managers or their nominated deputy will monitor on going competence of staff in performing all aspects of this skill. This will include adherence to Standard ANTT principles, correct hand hygiene and the removal of cannulae. This will be reported via the Saving Lives audit for Cannula Care which is monitored by Infection Prevention and Control, Matrons and IPC Link Nurses. If shortfalls are identified Managers with the support of Matrons and Infection Prevention and Control will develop action plans to resolve.

Staff Groups able to remove a peripheral cannulae

- Healthcare Practitioners must only remove peripheral cannulae if they are competent to do so according to these guidelines

2 Procedure to Follow

It is the responsibility of staff removing peripheral cannulae to ensure that patients understand the reason for the procedure and that the procedure involves minimum distress to the patient.

Infection control procedures must be adhered to, including the safe disposal of clinical waste as per Trust policy. Standard aseptic non touch technique must be adhered to throughout the procedure.

Positive Identification of the patient must occur.

The removal of peripheral cannula must be documented on the patients prescription chart and in patient notes (appendix A) or in outpatient areas in the patients safety questionnaire which is then scanned into CRIS.

Equipment required

Clinically clean tray containing prepared equipment

Gloves and apron as required for standard precaution measures

Sterile gauze/sterile

Tape

Clinical waste bag

Sterile medical adhesive remover if required

Procedure

- Identify the patient and explain the procedure. Obtain informed consent. In Paediatrics consider seeking support from the play specialists.
- Collect appropriate equipment in clean tray
- Wash and dry hands
- Put on gloves and apron
- Prepare sterile gauze to place over site, protecting key part at all times. Ensure you have checked integrity of gauze packet and its expiry date.
- Apply sterile medical adhesive remover to edges of IV3000 if required e.g. for infants and children.
- Use the 'stretch and pull' technique to activate the release properties of the IV3000 dressing. This will reduce the trauma to the patient's skin. **DO NOT USE SCISSORS**
- Inspect cannulae site for redness, oozing, swelling and tenderness. If there is evidence of infection take a swab and request a medical review
- Using Standard ANTT remove the cannulae using a slow and steady movement, applying firm pressure to the insertion site for at least a minute.
- Make sure that all components of the cannulae are present and intact when it is removed. Place this into the clinical waste bag. If cannulae not intact, keep faulty cannulae, raise a Datix incident form, log the LOT number of the cannulae and ensure a Medical Practitioner is informed of the situation.
- When the site has stopped bleeding/oozing, apply a new sterile gauze dressing and fix with tape. This should be inspected within 24 hours and removed.
- Make sure patient is comfortable and aware of any complications
- Remove gloves and apron
- Clean tray
- Wash hands with soap and water

- Documentation should include the VIP score and the date and time of removal of the peripheral cannulae on the patient's prescription chart (Appendix A) and in their clinical notes, in Paediatric areas record on Part B of admission paperwork.

3 Document Ratification Process

The design and process of review and revision of this procedural document will comply with The Development and Management of Trust Wide Documents.

The review period for this document is set as default of three years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be approved by the Nursing and Midwifery Operational Committee and ratified by the Director of Nursing or his Deputy

Non-significant amendments to this document may be made, under delegated authority from the Director of Nursing by the nominated author. These must be ratified by the Director of Nursing and should be reported, retrospectively, to the Nursing and Midwifery Operational Committee.

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades who are directly affected by the proposed changes

Dissemination and Implementation

Following approval and ratification, this procedural document will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Trust Wide Documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the Director of Nursing and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

4 Reference Material

- Dougherty L, Bravery K, Gabriel J, Kayley J, Malster M, Scales K, Wilkinson R (2010) **Standards for Infusion Therapy 3rd Edition**. Royal College of Nursing.
- Infection Control Nurses Association (2003) **Reducing sharps injury – prevention and risk management, Infection Control Nurse Association**. February. (U)
- Perruca R (2001) '**Obtaining vascular access**'. In **Intravenous therapy: clinical principles and practices**. Philadelphia: WB Saunders. (U)
- RCN (2011) **Sharps safety**. RCN. London.
- Weinstein SM (2001) **Plumer's principles and practice of infusion therapy**. 7th Ed. Philadelphia: Lippincott Williams and Wilkins. (U)
- Macqueen S, Bruce E.A. and Gibson F (Eds) (2012) **The Great Ormond Street Hospital Manual of Children's Nursing Practices**. Chichester: Wiley-Blackwell

Bibliography

- Arrowsmith J & Campbell C 2000 A comparison of local anaesthetics for venepuncture. Arch. Dis. Child 82 pp309-310
- Duff AJA 2003 Incorporating psychological approaches into routine paediatric venepuncture. Arch. Dis. Child 88 pp931-937
- Kelsey J., McEwing G. et al (2007) Clinical Skills in Child Health Practice. Churchill Livingstone
- Lavery I & Ingram P 2005 Venepuncture: best practice. Nursing Standard.19(49) pp 55-66
- May D& Brewer S 2001 Sharps injury: Prevention and Management. Nursing Standard. 15(32) pp45-54
- Rourke C, Bates C & Read RC 2001 Poor infection control practice in venepuncture and use of tourniquets. Journal of Hospital Infection. 49 (59-61) pp 59-61
- Strachan-Bennett S. 2004 Needles infect record number of staff. Nursing Times 100(38)
- Willcock J et al 2004 Peripheral venepuncture in infants and children 18(27) pp 43-50

Peripheral IV Cannula Record Sheet						
Daily Assessment on Drug Round						
Cannula Site, Colour & Batch Number:	Date Inserted:		DAY 1 24 hours post-insertion	DAY 2 48 hours post-insertion	DAY 3 72 hours post-insertion	Day 4 Remove or resite
	Name of Inserter: (please print name)	Date:				
		Time (24 hr clock)				
		Cannulation score: (please ring)	0 1 2	0 1 2	0 1 2	
		Cannula examined by: (print name)				
Emergency insertion: Yes / No	Cannula removed: Yes / No					
Cannula Site, Colour & Batch Number:	Date Inserted:		DAY 1 24 hours post-insertion	DAY 2 48 hours post-insertion	DAY 3 72 hours post-insertion	Day 4 Remove or resite
	Name of Inserter: (please print name)	Date:				
		Time (24 hr clock)				
		Cannulation score: (please ring)	0 1 2	0 1 2	0 1 2	
		Cannula examined by: (print name)				
Emergency insertion: Yes / No	Cannula removed: Yes / No					
Cannula Site, Colour & Batch Number:	Date Inserted:		DAY 1 24 hours post-insertion	DAY 2 48 hours post-insertion	DAY 3 72 hours post-insertion	Day 4 Remove or resite
	Name of Inserter: (please print name)	Date:				
		Time (24 hr clock)				
		Cannulation score: (please ring)	0 1 2	0 1 2	0 1 2	
		Cannula examined by: (print name)				
Emergency insertion: Yes / No	Cannula removed: Yes / No					
Cannula Site, Colour & Batch Number:	Date Inserted:		DAY 1 24 hours post-insertion	DAY 2 48 hours post-insertion	DAY 3 72 hours post-insertion	Day 4 Remove or resite
	Name of Inserter: (please print name)	Date:				
		Time (24 hr clock)				
		Cannulation score: (please ring)	0 1 2	0 1 2	0 1 2	
		Cannula examined by: (print name)				
Emergency insertion: Yes / No	Cannula removed: Yes / No					

**Contact doctor if any signs of redness, swelling or pus
Please question: Is the cannula still needed?
Could IV medication be switched to oral?**

Cannula Site Assessment Tool (VIP score)			
Score	0	1	2
Pain	Nil	Yes	Yes
Erythema / Swelling / Induration	Nil	Nil	Yes
Action	None	Observe Carefully Consider replacing	Remove

Appendix

Appendix B

Competency for removal of Peripheral Cannula

Name: _____ **Designation:** _____

Assessor: _____ **Designation:** _____

Ward/Dept: _____

Aim: To demonstrate safe removal of peripheral cannulae.
Objectives: The candidate will be able to:
 Demonstrate an understanding of the knowledge and skills necessary for removal of cannulae.
 Demonstrate competency in performing the procedure
Update: Competence to be reviewed annually at appraisal

Training Prerequisite

Prior to this assessment, I have successfully completed the following:

Prerequisite Training	Yes/No	Date
Candidate must have achieved enough supervised practice to feel confident to complete the practical assessment		
Be aware of policies supporting this procedure		

Candidate Signature: _____ **Date:** _____

Assessment Criteria	Competent Y/N
PREPARATION OF PATIENT AND CANDIDATE	
1. Candidate positively identifies the patient, explains the procedure, and gains informed consent;	
2. Candidate collects the appropriate equipment and clinically cleans the tray with disinfectant wipes;	
3. Candidate demonstrates thorough hand washing using Ayliff six stage technique and applies PPE;	

STANDARD ASEPTIC NON TOUCH TECHNIQUE (ANTT)	
4. Candidate opens and prepares all necessary equipment using an aseptic non touch technique (ANTT), protecting key parts. Standard ANTT will be used for removal of cannulae.	
5. Candidate prepares sterile gauze to place over cannulae site once removed.(Key site) Check expiry date and integrity of packaging.	
6. Candidate elongates IV 3000 dressing in order to activate the self-releasing properties, reducing the trauma caused to the skin, Do not use scissors.	
7. Candidate inspects cannulae site (Key site) observing for redness, swelling or tenderness.	
8. Candidate removes cannulae using a slow, steady movement applying firm pressure to the insertion site for at least one minute with sterile gauze	
9. Candidate inspects the removed cannulae, ensuring that all components are intact and places in a clinical waste bag. If cannula is not intact, raises a Datix incident, keeps faulty cannulae and informs Medical Practitioner responsible for the care of the patient.	
10. Candidate applies a sterile dressing	
11. Candidate ensures the patient is comfortable, aware of any complications and able to reach call bell, drinks etc. prior to leaving the bedside;	
12. Candidate removes gloves and disposes of waste as per Trust policy and washes hands with soap and water;	
13. Candidate documents the date and time of removal of peripheral cannula on patients' prescription chart and notes.	

<u>ASSESSOR</u>	
I certify that _____ has completed all of the required aspects of this competency	
Signed: _____	Print Name: _____
<u>CANDIDATE</u>	
I confirm that I have had theoretical and practical training on cannulae removal and I consider myself to be confident and competent to remove this device without further training. I agree to comply with trust policies and procedures at all times.	
Signed: _____	Print Name: _____
Designation: _____	Date: _____

MANAGERS AUTHORISATION

Manager's signature providing authority for practitioner to perform this skill.

Signed: _____ **Print Name:** _____ **Date:** _____

ACTION PLAN (if competencies not achieved)

If not competent the candidate must remain under supervision until assessed as competent, if still not competent after second attempt manager must refer to performance management policy and date must be planned for reassessment of competence

Assessor's Signature: _____ **Candidates Signature:** _____

Date of Reassessment: _____