

PROCEDURAL SAFETY CHECKLIST

Before any medical or patient care procedure, review checklist together with the other members of the procedural team. This checklist can be used by any health professional as a self-assessment tool before performing any procedure.

Ensure that **patient and health care provider safety standards** are met during this procedure including:

- Risk assessment and appropriate PPE
 - 4 Moments of Hand Hygiene
 - Two patient identification
 - Safe patient handling practices
 - Biomedical waste disposal policies
- Are there any contraindication or increased risk to this procedure that require additional consideration (e.g. prolonged INR/PTT, spinal cord injury, pregnancy, renal impairment)
 - Does the patient have allergies (including allergies to latex, skin preps, tapes, local anaesthetics or catheter coatings)?
 - Does the individual performing this procedure have the knowledge, skill and experience to perform **THIS** procedure in **THIS** particular patient without assistance?
 - Who else should be called to assist with this procedure (e.g., senior resident or consultant, another medical team, respiratory therapy)?
 - Is consent required (informal or formal) and has the procedure been explained to patient/family?
 - Are additional people required to ensure safety (e.g., for patient positioning or to prevent contamination of a sterile field)?
 - Is analgesia or sedation required?
 - Have team members reviewed any procedural checklists and “talked through” the procedural steps BEFORE starting the procedure to ensure everyone knows what to expect and all necessary supplies have been assemble?
 - Have team members anticipated and prepared for possible complications should they develop?
 - Are there follow-up diagnostic tests or investigations that need to be ordered (e.g. chest xray, blood cultures)?
 - Complete required checklists and document procedure, patient response and complications

Quality Bundles:

VAP Reduction Bundle

VAP REDUCTION BUNDLE

- 1. HOB \geq 30 degrees** if intubated or a tracheostomy tube is in place, except during temporary procedures (e.g., bed changes, line insertion) unless contraindicated*
- 2. Maintain appropriate level of sedation:**
 - ✓ Adjust sedation to target VAMAAS
 - ✓ Q shift SWAP and attempt dose reduction of continuous sedatives unless contraindicated*
- 3. Daily SBT**
 - ✓ Screen daily for SBT readiness
 - ✓ If screen is passed, conduct SBT daily*
- 4. Subglottic Secretion Drainage (SSD)**
 - ✓ SSD for all patients with endotracheal tube
 - ✓ If intubated without SSD, review during rounds re suitability for possible tube exchange
- 5. Initiate safe enteral feeding within 24-48 hours** unless contraindicated*
 - ✓ Attempt small bowel placement for all feeding tubes
 - ✓ Avoid nasal placement for gastric drainage tubes; remove and replace orally within 48 hrs unless contraindicated (e.g., esophageal/oral surgery or varices)
- 6. Oral decontamination**
 - ✓ Oral hygiene with teethbrushing per CCTC procedure
 - ✓ Chlorhexidine oral rinse Q12H (unless contraindicated*)

* See reverse for details

VAP Reduction Bundle Details

1. **HOB Elevation:** Document HOB elevation in degrees in 24 Hour Flowsheet with each change in position.
 - HOB ≥ 30 degrees may be contraindicated or require modification in a number of situations, such as: unclear C-spines, open abdomen, hemodynamic instability, patient discomfort, skin breakdown, femoral lines, sleep disturbance or where alternate HOB elevation has been ordered.
 - If HOB < 30 degrees, the reason must be documented in the AI record. For hemodynamic instability or patient discomfort, reassess Q 4H and position HOB at highest tolerated level.
2. **Sedation Assessment and Weaning:**
 - a) **Adjust analgesia and sedation to target VAMAAS:** Chart VAMAAS or MAAS in 24 Hour Flowsheet, recording the “typical” score for the preceding hour.
 - Q shift for all patients
 - Q 4H and prn for patients receiving sedatives
 - Chart the VAMAAS on the MAR to explain reason for PRN sedation.
 - Q shift, document a DAR note under the heading “comfort”. Document overall assessment findings re pain, anxiety, and delirium. Include treatments and response
 - b) **Screen Q shift and prn for sedation weaning readiness:**
 - Screen for sedation weaning readiness Q shift using Sedation Weaning Assessment Tool (SWAP) unless deep sedation (VAMAAS 0) is the target (e.g., acute brain injury, hypothermia protocol, neuromuscular blockers, open abdomen, etc).
 - If SWAP passed, initiate sedation weaning as per orders
 - If SWAP failed, review sedation plans during rounds
 - Document SWAP, weaning strategy and response
3. **Contraindications to SBT (reasons for screening failure):**
 - Underlying reason for ventilation has not been resolved (e.g., cardiogenic shock, acute brain injury, hypothermia protocol)
 - Use of deep sedation or paralytic agents (continuous or intermittent)
 - Inability to initiate spontaneous effort
 - Hemodynamic instability (including use of vasoactive infusions)
 - PaO₂/FiO₂ ratio ≤ 200 on > 0.5 FiO₂ or PEEP > 8 or pH ≤ 7.30 *
 - Medical order
 - **See SBT Screening:**
http://www.lhsc.on.ca/Health_Professionals/CCTC/protocols/SBT.pdf
4. **Contraindications to Subglottic Secretion Drainage (SSD):**
 - An SSD is not used if a patient requires a tube other than a standard endotracheal tube (e.g., blocker tube, armoured tube)
5. **Initiate enteral feeding within 24-48 hours:**
 - Contraindications must be documented in clinical record. Bundle compliance is confirmed if a contraindication is documented, or if feeding is started within 48 hrs of an order to initiate enteral feeding in a patient with prior contraindications.
6. **Oral decontamination with chlorhexidine and oral care with teeth/tongue brushing:**
 - Contraindications to teethbrushing includes adentulous or recent oral surgery. Document oral care in 24 Hour Flowsheet.
 - Contraindications to Chlorhexidine include allergy or medical order (e.g., following recent oral surgery).

Quality Bundles: Insertion of Arterial or Central Venous Line

Ensure that patient and health care provider safety standards are met during this procedure including:

- Risk assessment and appropriate PPE
 - 4 Moments of Hand Hygiene
 - Two patient identification
 - Safe patient handling practices
 - Biomedical waste disposal policies
1. Pause to review procedure and assemble necessary equipment
 2. Review allergies to skin preps, tapes or catheter materials (e.g. latex, heparin, chlorhexidine, silver sulfadiazine, minocyclin or rifampin). Note: our standard central line catheter include 2 of these 4 antimicrobials).
 3. Ensure appropriate catheter length for IJ/SC (16 cm NOT 20 cm)/ Catheter model, length, size and product number should be confirmed by provider and documented in procedure note.
 4. Guidewire exchange should be avoided. If required, rationale for guidewire exchange should be documented
 5. Insertion of a multilumen catheter into an established introducer requires full barrier precautions. It should only be done if introducer was inserted using maximal precautions and a sterile introducer cap has been maintained.
 6. Hair removal with clippers before skin cleansing and draping
 7. Scrub skin vertically and horizontally for 30 seconds with chlorhexidine 2% in 70% isopropyl alcohol
 8. Allow skin to dry 2 minutes after cleaning
 9. Cap, mask with face shield, sterile gown and sterile gloves for individual(s) performing or supervising insertion
 10. Cap and mask for all individuals within 1 meter of sterile field
 11. Broad draping of sterile field
 12. Flush lumens of central venous lines with normal saline provided in sterile packaging
 13. Inserter must complete Central Venous and Arterial Line Checklist and Procedure note and complete follow-up assessment
 14. **Any member of the team can stop a procedure/identify breaks in technique**
 15. **Procedure note should accurately reflect adherence to protocol to identify lines that should be changed**

Maintenance Bundle for all Intravascular Devices

Ensure that patient and health care provider safety standards are met during this procedure including:

- Risk assessment and appropriate PPE
 - 4 Moments of Hand Hygiene
 - Two patient identification
 - Safe patient handling practices
 - Biomedical waste disposal policies
1. Review insertion date, circumstance and need for continued line use Q shift.
 2. Change lines inserted without full precautions within 24-48 hrs (document plan)
 3. Palpate and visually inspect site daily
 4. Ensure catheter securement; change/remove positional lines
 5. Change transparent dressings Q7 days and PRN if soiled, integrity is disrupted, edges are curled or CHG pad feels “boggy” .
 6. Change gauze dressings daily
 7. Apply needleless access device to all injection and blood sampling ports (connect pressure tubing directly) to catheter hub.
 8. Back flush sampling ports (into vacuum tube) after blood drawing. Replace needleless access device when soiled or blood remains present
 9. Apply new antiseptic cap to all injection and sampling ports and to the male end of any vascular tubing during temporary disconnection after each access.
 10. Scrub the hub and allow 30 second dry time before accessing ports without antiseptic cap.
 11. Flush lines thoroughly after blood sampling. Flush EACH PICC lumen with 20 ml using turbulent flushing (stop/start technique) after blood sampling or each time a locked device is accessed
 12. Routine tubing changes: a) TPN and insulin Q 24 hrs, b) blood tubing after 2 units (except rapid infuser), c) propofol bottle and tubing Q12 hrs, d) all other sets Q 96 hrs and PRN .
 13. Maintain dedicated line for TPN
 14. Don non-sterile gloves and do not touch insertion site after skin prep for venipuncture and peripheral IV insertion.
 15. Maintain aseptic technique for peripheral IVs and document compliance
 16. Document assessment findings in the intravascular section of the 24 Hour Flow sheet Q shift and PRN and update Kardex.
 17. Blood cultures:
 - a) Minimum of 2 sets for any culture event
 - b) Change needleless access cap BEFORE blood culture sampling
 - c) Include discard sample UNLESS IT CONTAINS CITRATE
 - d) If line > 48 hrs, send venipuncture AND line culture(s) and request “CAB” assessment. Draw and order all samples within a 15 minute timeframe and send all bottles in one bag (or bags wrapped together)
 - e) Identify catheter site and type (e.g., R IJ HD) and date of central and arterial catheter insertion (including PICC/HD lines) when ordering cultures
 18. **Every member of the team is expected to remind others/stop procedures if any steps are overlooked**

Dressing Change

Arterial and Central Venous Lines

Ensure patient and health care provider safety standards are met during this procedure including:

- Risk assessment and appropriate PPE
 - 4 Moments of Hand Hygiene
 - Two patient identification
 - Safe patient handling practices
 - Biomedical waste disposal policies
1. Assess patient's ability to maintain positioning and obtain assistance as required
 2. Administer analgesic or sedation as needed before starting procedure.
 3. Assist others to meet dressing change standards; correct application reduces central line infection risk and usually results in less frequent dressing changes.
 4. Apply CHG transparent dressing unless excessive oozing. Change Q7 days and PRN
 5. Use gauze dressing for oozing site. Change DAILY.
 6. Remove hair PRN using sterile clippers BEFORE skin cleansing and draping.
 7. Obtain sterile Central Line and Arterial Line Dressing Tray, plus dressing, sterile gloves and Cavilon™

Dressing Change Steps:

1. Perform hand hygiene, then open dressing tray
2. Don clean bouffant, gown and mask with face shield, then perform hand hygiene
3. Prepare dressing tray aseptically. Add supplies using transfer forceps
4. Don clean gloves.
5. Remove old dressing and perform hand hygiene.
6. Don sterile gloves.
7. Drape area
8. Remove securement device if present
9. Cleanse skin:
 - i. With first swab, scrub skin in vertical direction while moving from one side to the other.
 - ii. Flip swabstick over and scrub in a horizontal direction, moving swab from top to bottom.
 - iii. Using second swabstick, scrub catheter tubing (entire area that will lie below the dressing).
 - iv. Lift tubing, flip swabstick over and scrub undersurface of tubing.
10. Allow skin to dry a MINIMUM 2 minutes; *inadequate dry time causes of skin reactions*
11. Apply Cavilon™ (AVOID INSERTION SITE AND AREA UNDER CGH PAD). Minimum 1 minute dry time
12. Apply new securement device if indicated
13. Apply dressing, pressing slowly from site toward outer edges
14. Tape catheter to prevent it from pulling on the dressing. For jugular IVs, individually taping of each lumen after looping in a downward direction helps to reduce traction on dressing.
15. Perform hand hygiene at end of procedure
16. Ensure that tracheostomy ties and cervical collars do not come in contact with dressing.
17. Document dressing changes and assessment findings Q shift and PRN in intravascular section of 24 Hour Flow sheet and update Kardex.
18. **Every member of the team is expected to remind others/stop procedures if any step is missed**