

GUIDELINES

AAGBI: safer vascular access 2016

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Summary

Safe vascular access is integral to anaesthetic and critical care practice, but procedures are a frequent source of patient adverse events. Ensuring safe and effective approaches to vascular catheter insertion should be a priority for all practitioners. New technology such as ultrasound and other imaging has altered the tools available. This guidance was created using review of current practice and literature, as well as expert opinion. The result is a consensus document which provides practical advice on the safe insertion and removal of vascular access devices.

Recommendations

1. Anaesthetists should optimise their recognition and management of complications; these should be audited locally and nationally.
2. Real time ultrasound guidance should be used in all central venous catheter insertions, and other access where applicable, to increase success and safety of procedures.
3. All anaesthetists should be proficient in using intra-osseous access devices, which should be available in all acute settings
4. Anaesthetists should be proactive in provision of, training in and supervision of vascular access.

5. Hospitals should establish lead clinicians for vascular access
6. Anaesthetists should review educational processes to improve safety and efficiency of procedures.
7. All patients should have access to a timely, safe and effective central venous catheter service.

- *What other guideline statements are available on this topic?*

There are a small number of existing national and international guidelines on vascular access [1-5].

- *Why was this guideline developed?*

There is a need for up to date evidence based guidance focusing on patient safety. There continues to be cases of severe morbidity and mortality related to vascular access [6-7].

- *How and why does this publication differ from existing guidelines?*

This is the first UK Anaesthetic national guidance in this field, primarily aimed at safety of insertion and removal procedures. We also highlight organisational and training issues.

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Introduction

Vascular access is the most common invasive procedure undergone by patients in secondary care. It is often poorly undertaken and is the source of considerable patient discomfort, inconvenience as well as morbidity and mortality. Vascular access is essentially a single often repetitive task but providing a quality service requires more; this includes all aspects of human factors as well as education, training, audit and technical proficiency. New technology such as ultrasound and other imaging is altering practice.

Peripheral venous cannulation

Peripheral venous cannulation is the commonest, and probably the most important invasive procedure practised in hospitals. Principles are summarised in Table 1 [8-11].

An alternative and increasingly used technique is so called midline catheters [12]. These are approximately 15cm long and inserted into upper arm veins with ultrasound (as with a PICC), such that the tip lies outside central veins and are used for short to medium-term access (e.g. one to four weeks antibiotics), but not for vein-damaging infusions.

Intra-osseus access

Intra-osseus access (IO) access is useful in emergencies, when intravenous (IV) access is difficult, and is faster than central access [13]. It can be used for resuscitation fluids and drugs. All acute care clinicians should be familiar with techniques and have ready access to devices. We suspect that to date this is not the case in most centres. A number of manual and automated devices exist.

The tibia and the humerus are preferred sites. For the tibia, the insertion site is 2cm distal to the tibial tuberosity and 1cm medial to the tibial plateau. Care is needed to avoid the epiphyseal growth plate in children. The humeral site is 1cm cephalad to the surgical neck. Success is evident by: aspiration of bone marrow (painful in awake patients); saline flush with no extravasation; support of the needle by the bone cortex; and infusion under gravity alone.

Complications include: fracture; extravasation; osteomyelitis; infection; compartment syndrome; growth plate injury; and pressure necrosis of the skin. Devices should be removed as soon as suitable IV access is achieved, ideally within 24 hours of placement.

Arterial access

Relative contraindications include severe peripheral vascular disease, coagulopathy and local synthetic grafts. There is no evidence to support routine rotation of sites. Compression of radial and ulnar arteries to assess collateral perfusion (Allen's test) seems intuitive but is unreliable. Ultrasound can be used to assess vessel patency and size.

Methods of insertion include: catheter-over-needle; and catheter-over-wire i.e. Seldinger or modifications. A meta-analysis [14] suggested that radial arterial cannulation with ultrasound is more successful on first attempt. Major procedural complications (e.g. permanent ischaemic damage, sepsis, pseudoaneurysm) occur in < 1% of cases and are similar for radial, femoral, and brachial sites. Some studies have found a higher incidence of catheter related infection in femoral sites.

There have been UK national alerts on severe hypoglycaemia from misdirected administration of insulin when glucose solutions are used to flush arterial lines. Association of Anaesthetists of Great Britain and Ireland guidelines recommend saline +/- heparin as the only safe flush solution [15].

Insertion & removal of central venous catheters

Device choice

This depends on: patient diagnosis; the intended treatment (irritant drugs normally require CVC); and patient choice. Devices should have the minimum number of lumens required [16], and the lowest functional diameter. Parenteral nutrition requires a dedicated lumen. Fixed-length catheters: 15cm for right internal jugular vein, 20cm for left internal jugular or right axillary/subclavian vein, and 24 cm for left axillary/subclavian or femoral vein, are the usual minimum selection length for adults. See Table 3 for different features [16, 17].

Route of access

Central venous catheters

The internal jugular vein route may have a lower risk of mechanical complications than the subclavian [1]. Recent work shows catheter related bloodstream infection rates are lower in critical care patients using the, subclavian rather than IJV or femoral routes [18], although the groin may have a higher microbial colonisation rate. Tunneling devices away from the groin may reduce such risks. Some perceived differences in complication rates may disappear with optimal catheter tip positioning. The right internal jugular/femoral route provides a straighter course to central veins, making catheter positioning easier without X-ray guidance.

Peripherally inserted central catheters

These should be used with caution in patients at risk of ipsilateral lymphoedema and those who may require an arterio-venous fistula. The basilic and brachial veins may have a lower thrombosis rate than the cephalic vein. Ultrasound use may avoid damage to the median nerve and brachial artery. Use of upper arm veins avoids the elbow flexure.

Catheter tip position

A poorly positioned catheter tip may increase the risk of complications, e.g. thrombosis, erosion and pericardial tamponade [19]. The position of the tip moves with respiration and patient position. Upper body CVCs should be positioned with the tip parallel to the vessel wall, usually in the lower superior vena cava (SVC) or the upper right atrium (RA). Common sites for tip misplacement include: high SVC; internal jugular vein; angled at vein wall; low RA; right ventricle; innominate vein; and subclavian vein.

Assessment of tip position includes; post-insertion chest X-ray, real-time fluoroscopy, and ECG guidance. Stenosis or distortion of great veins is common in disease states particularly with prolonged CVC placement. Unusual congenital variants (e.g. left SVC) exist [20]. Misplacement can be reduced by the following: use of the right internal jugular vein; or femoral veins and pressure over the internal jugular vein. Catheters and guidewires may pass centrally more easily on inspiration as thoracic structures change shape. Ultrasound can confirm catheter position with supraclavicular, transthoracic and transoesophageal echocardiographic views. Electrocardiography and electromagnetic guidance are increasingly used to guide catheter tip positioning as per recent NICE guidance [21]. Fluoroscopy +/- X-ray contrast remains the gold standard for imaging.

Most misplaced CVCs are easily identified on chest X-ray, but signs can be subtle [20]; judicious use of contrast via the catheter (linogram) is helpful. The limitations of single plane Xray imaging must be appreciated. Clues to misplacement include: pain on injection; difficulty in aspirating blood from one or more lumens; or an abnormal pressure waveform. Management of misplaced catheters includes: using the device if it is safe to do so; manipulating the position under Xray guidance; or replacement, using fluoroscopic guidance or other imaging as required.

Removal of CVCs

Devices should be removed when they are no longer required or are causing problems. The patient should lie flat with the exit site below the heart to reduce risks of air embolus. Firm digital pressure should be applied for at least five mins, followed by an occlusive dressing. Routine culture of tips is not considered necessary. Persistent bleeding may require a skin stitch.

Cuffed devices/ports need surgical cut-downs as they develop complex adherent fibrin sleeves and scar tissue [22]. Fibrin sleeves are frequently left behind within the vein (seen as

'ghosts' on ultrasound). Very long-term catheters may become attached to the wall of SVC/right atrium and cannot be removed by traction alone; cutting off and leaving in-situ or surgical removal may be required. Devices can become knotted within veins. Seek advice from vascular surgery or interventional radiology if difficulties occur.

Procedures in coagulopathic patients

In the presence of a coagulopathy, a more experienced operator should insert the CVC, ideally at an insertion site that allows easy compression of vessels. Femoral access may have a lower risk in this situation. Routine reversal of coagulopathic abnormality is only necessary if platelet count $< 50 \times 10^9.l^{-1}$, activated partial thromboplastin time > 1.3 times normal and/or international normalised ratio > 1.8 , as the risk of haemorrhage is otherwise not increased [23]. In selected patients, different thresholds for correction may be acceptable.

Bleeding risks of insertion and removal vary with the site, size of device, and operator experience. The risks of correction (e.g. infection, lung injury, thrombosis) may exceed that of local bleeding, and it may be preferable to give blood products if problems occur, rather than prophylactically.

Difficult central venous catheter insertion

Difficult access occurs frequently [24] and is more likely with previous multiple attempts, insertion site scars, and long-term access. Distended superficial collateral veins suggest deeper blockage. Doppler ultrasound of great vessels gives limited imaging of the subclavian vein and SVC; contrast venography/CT/MRI may be indicated, dependent on urgency.

If difficulty is predicted, insertions should be performed under X-ray control with appropriate radiation protection [25]. High-resolution ultrasound should be used with colour Doppler to study flow. Input from interventional radiology and surgery may be needed.

A 'difficult access' trolley is useful, with additional instruments, sterile Xray drapes and ultrasound probe covers, standard (18G) and micro-puncture needles (20-21G), and compatible guidewires (0.018" and 0.32").

Guidewires come in various lengths, with different coatings and tips (e.g. straight, angled, soft tip or full 'J'). It is best to be familiar with a small range. Catheters of 12-30 cm length should be available for adults. Guidewires should be checked for damage and adherent clot removed with a wet swab. A selection of compatible dilators and peel-away sheaths is needed.

Use of a 4-5 Fr introducer sheath allows manipulation of guidewires while minimising the risk of damaging the wire or vein; it also acts as a conduit for contrast injection or advancement of specialist catheters/wires.

X-ray contrast is used to image vascular anatomy, identify complications and confirm line position/patency. It may cause anaphylaxis. Contrast nephropathy is unlikely in doses used for venous access [26].

Paediatric CVC insertion

Provision of CVCs for neonates through to adolescents is challenging, despite similar techniques to adults. Children are more likely to be seen with congenital cardiac anomalies and there is a large range in the size of vessels, which impacts on procedures and complications [27]. Most procedures will be conducted under general anaesthesia, except for peripherally-inserted central catheters.

Catheter choice depends on: vein calibre; indication; duration of use; severity of illness; and operator experience. Neonatal long lines down to 28G are available. Umbilical venous catheters remain popular for short-term use in neonates, despite high complication rates. Non-tunnelled, 5-6 cm long, 4.5-Fr triple-lumen CVCs are available for neonates. Tunnelled cuffed Broviac catheters for long-term use are available down to 2.7Fr [28].

A full range of sizes of equipment is required. Operators must be familiar with equipment and procedures. Typical guidewires are narrower 0.021" (0.032" used in adults), and prone to kinking, particularly during advancement of dilators. The diameter of a "J" tip may impede advance in a narrow vein. A less curved tip is preferable. Skin dilators tend to be shorter and narrower.

X-ray imaging of fine catheters is challenging, and contrast may be required. There are few data on the use of electromagnetic or ECG guidance to identify CVC tip position in children. X-ray guidance remains standard.

Chlorhexidine of varying strengths is used for skin antisepsis prior to CVC insertion in infants, but efficacy and safety data comparing solutions is lacking so definitive guidance cannot be given. Chlorhexidine, in particular 2%, has been associated with skin erythema and burns in premature infants and caution is advised in this group; the use of excessive quantities of Chlorhexidine and its pooling on the skin should be avoided [29].

Ultrasound-guided paediatric CVC insertion has been shown to be superior to landmark techniques [30]. Superficial vessels and lack of fat allows excellent imaging. Probes need a small footprint for skin contact. Veins are prone to compression by the probe and access needle, which risks of transfixion and damage to adjacent structures.

Children are less likely to understand the importance of their CVC with risks of damage. Implanted ports may not be tolerated by needle phobic children. Rapid growth may lead to the tip migrating.

Peripheral access can be challenging and limit placement of devices. Loss of peripheral veins is a serious issue in chronic illness. Prolonged use of CVCs may lead to vessel thrombosis with difficult or impossible access. Open surgical cut-down remains a common technique in paediatric surgery and often leads to central vein occlusion near the entry site.

Prevention, recognition and management of central venous catheter complications

Deaths related to CVCs are often accompanied by poor documentation [4]. All hospitals should have clear, specific policies for insertion and documentation of CVCs (type, insertion site and tip position), and education on complications and their surveillance.

Publications suggest complication rates of 1-26% [31]. However, most series are small and lack precise denominators. Appropriate training and surveillance should avoid and identify most complications. Discussion here is limited to more serious complications (Table 4), which vary in frequency depending on patient, catheter, and operator factors.

Infection

Central venous catheter-associated bloodstream infection can be life-threatening, and is increasingly regarded as a measure for quality of care. Treatment should adhere to local guidance and may include CVC removal [32].

Thrombosis / thrombo-embolism

Thrombosis related to CVCs has a reported incidence of 3-32% [1], reflecting variations in definition and imaging, and frequent asymptomatic cases. Effective prevention includes: insertion of the narrowest-bore catheter possible for treatment needs; placement of the tip in lower SVC/high right atrium; and early removal.

Evidence suggests that peripherally-inserted central catheters are associated with increased peripheral and central thrombosis [33]. The femoral route may be associated with a higher thrombosis risk [18-19]. Some retrospective (but not prospective) studies show an increased thrombosis risk when the subclavian vein is used long-term [1]. Anticoagulation is not currently recommended for asymptomatic thrombosis [1], or as prophylaxis, except for patients at high risk (e.g. previous DVT or PE) [34].

Thrombosis may present with a poorly functioning line; swollen limbs; signs of SVC obstruction; pain over the insertion site; or central embolism. Symptomatic thrombosis is usually

treated with full anticoagulation. Removal of a functioning CVC depends on the clinical situation, and ease of re-insertion.

Perforation of great vessels and myocardium

These complications usually occur at insertion and may cause serious morbidity or mortality. Meticulous technique, vigilance and early recognition prevent progression to catastrophe. Bleeding may be evident externally or covert into pleurae, pericardium, and peritoneum.

Arterial puncture

Inadvertent arterial puncture is reduced with routine use of ultrasound guidance [1, 35]. It is usually evident by bright red, pulsatile blood, but confusion may occur in infants and emergency situations. Manometer tubing can be attached to a needle or cannula to differentiate venous from arterial placement. Ultrasound imaging can confirm the guidewire in the proximal vein before dilatation. A PO_2 consistent with arterial blood is strongly suggestive but may reflect arterio-venous shunting. All tests have flaws; a fuller discussion is available elsewhere [2].

Needle puncture is managed by removal and digital pressure. Ultrasound imaging may define the size of haematoma, vessel injury and patency. Puncture of the carotid artery with a 21G 'searching' needle may cause stroke, particularly with existing arterial disease [36]. If the needle also traverses a vein, there is potential for an arterio-venous fistula. Expanding neck haematoma in the neck may fatally compromise the airway [37-39], and require intubation and surgical intervention. Haemorrhage associated with the femoral route may be concealed in the retroperitoneum. Tense haematomas elsewhere may require surgical evacuation/repair to prevent local pressure effects.

Inadvertent arterial cannulation

The incidence is estimated as 0.1-1% [1]. There may be excessive bleeding along the guidewire or on passing dilators and introducers. Activation of high-pressure alarms on infusion pumps and retrograde flow within catheter/infusion sets are suggestive. Chest X-ray may show an abnormal catheter path (to the left mediastinum), but not if the catheter is in the right carotid or ascending aorta which are adjacent to the internal jugular vein and SVC. An arterial waveform upon pressure transduction (check settings are for arterial range) confirms arterial positioning. Contrast injection will demonstrate arterial flow and CT shows the catheter course. Carotid artery cannulation carries a higher risk of morbidity and mortality than at other sites, because of the risk of stroke.

Larger catheters/dilators (6Fr or greater) should be left in place and their safe removal discussed urgently with interventional radiologists or vascular surgeons. Management of smaller catheters depends on the insertion site, presence of arterial disease or thrombus, and coagulation status; catheters (5Fr) are routinely removed from the femoral artery following radiology procedures. This is followed by direct pressure for ten minutes, or until haemostasis is achieved, then six hours bed rest. Such guidance can be followed for inadvertent femoral artery catheterisation. Interventional radiologists and surgeons should be consulted before removing any arterial catheter from the neck or chest, or from any site in an anticoagulated patient [38]. Routine anticoagulation following short-term inadvertent carotid or subclavian artery catheterisation is not recommended.

Venous tears

This is caused by trauma during insertion or later erosion of the vein wall. Prevention includes meticulous insertion technique; avoidance of advancing guidewires and dilators against resistance; and firmly holding guidewires during dilation and catheter advancement. Poorly positioned catheters need to be repositioned, including left-sided upper body CVCs that abut the SVC at an acute angle. Narrow-bore soft catheters and dilators are less likely to cause perforation

Venous injury may manifest as a haematoma, bleeding or extravasation into the mediastinum, pleura, peritoneum, pericardium or other space. It may cause haemodynamic compromise, cardiac tamponade, haemothorax or pleural effusion [37, 39]. The catheter should remain in situ until a vascular surgical or interventional radiology opinion has been obtained.

Myocardial perforation / cardiac tamponade

This can be caused by trauma from guidewires or dilators during insertion, or later erosion by a catheter. Presentation is usually acute but may be delayed until infusion of fluids via the catheter. The incidence is reduced by careful insertion techniques. Infants and those with dilated cardiomyopathy or previous cardiac surgery are at higher risk. Guidewires should be advanced gently and not beyond 20cm (less in children) without imaging. Dilators should only be inserted as far as required to create a tract to the vessel. Traditionally, it was advocated that catheter tips should lie above the pericardial reflection but this is frequently not possible, particularly with left-sided catheters.

There may be signs of obstructed shock, an abnormal pressure wave, or cardiac arrest. Chest X-ray may show an enlarged cardiac outline, which can be confirmed with

echocardiography. Management involves attempted fluid aspiration through the catheter, urgent pericardiocentesis or surgical intervention [39].

Pneumothorax

The incidence of pneumothorax is 0.3-2.3%, highest with the subclavian route [1, 33]. It is typically caused by needle penetration of the visceral pleura. Prevention includes avoiding the subclavian vein, particularly during early training, and using ultrasound guidance [40]. Recognising a pneumothorax can be difficult. It may be invisible on initial post-procedure imaging. Staff and patients should be warned to report late signs and symptoms.

Treatment options include observation; administration of supplemental oxygen; and aspiration; or tube drainage. Minimal or asymptomatic collections (up to 30% of the pleural cavity) may not require drainage in spontaneously breathing patients.

Haemothorax

This may occur with central vein or arterial trauma [41]. The pleurae are low-pressure spaces, where a large volume of blood can accumulate. Catheters crossing from a vein or artery into the pleura (or other space) may be wholly or partially occluding the hole and bleeding may worsen on removal. Further accumulation of fluid/blood may occur if the catheter is used for infusion, resuscitation or dialysis.

There may be clinical signs of respiratory and/or circulatory failure. Chest X-ray, CT or ultrasound imaging shows a dense pleural effusion, and aspiration/drainage of blood confirms the diagnosis. Resuscitation with drainage and repair of the damaged vessel may be required.

Cardiac arrhythmias

Arrhythmias may be precipitated by guidewires or catheters stimulating the heart [42]. They are usually caused by insertion beyond the predicted length of catheter for that insertion site, and usually settle on guidewire/catheter withdrawal. Electrocardiographic monitoring throughout all upper body CVC insertions is advisable.

Venous air embolism

Air embolism may be fatal and occur at any time from insertion to removal. The incidence may be 0.8% [41]. Prevention requires careful insertion/removal techniques, secure fixation and safe handling when accessing the catheter. Presentation ranges from subtle neurological, respiratory or cardiovascular signs to shock, loss of consciousness and cardiac arrest. Chronic forms may exist. If suspected, damaged catheters should be clamped, pressure and wet dressings applied, and occlusive dressings used. Head-down, left lateral tilt and attempted aspiration of air via the line may be useful.

Guidewire and catheter embolus

This risk is increased during difficult or multiple cannulation attempts of the same vessel, or the presence of an inferior vena cava filter [43]. Preventative measures include minimising the length of guidewire advanced, and maintaining hold of the outside section. Guidewire counts or mandatory witnessed documentation of guidewire removal may help identify unaccounted wires during insertion. Retained guidewires are usually asymptomatic and recognised incidentally on X-ray. Guidewire retention is now categorised as an NHS Never Event [44].

Catheter embolism occurs more often with long-term devices. Catheter and port hub connections may fracture/disconnect. Compression of the catheter between the first rib and clavicle may result in 'pinch-off' [45]. Catheters are at risk during removal, especially cuffed/implanted devices.

Both complications need referral for urgent radiological or surgical retrieval.

Catheter occlusion

Occlusion may be due to thrombus, fibrin sheath, or precipitation within the catheter. The incidence of catheter occlusion may be reduced by adhering to standard procedures for accessing CVCs and managing failing lines. A Cochrane review of heparin solutions reported no reduction in intra-catheter thrombus [46]. Occlusion is recognised by inability to aspirate or flush one or more catheter lumens. It is common, and often managed by a local protocol. A 'linogram' may identify a kinked catheter, aberrant tip position, or a fibrin sheath with reflux of contrast. Thrombolytics can be used to clear the lumen [47]. In the case of precipitants, strong acid or alkali has been used to unblock devices.

External catheter breakage

The portion of a CVC outside the body has the potential to be cut, break or split. Breakage is more common in long-term lines. They may be repaired according to local policy, or replaced.

Extravasation injury

Injury caused by leakage of infusate is usually associated with catheter damage or withdrawal (placing a luminal hole outside the vein), or vein perforation. Rarely, fluid backtracking along a fibrin sheath may be the cause. High-risk infusates include those with high or low pH, high osmolality, vasopressors and chemotherapy agents.

Secure fixation is important to minimise withdrawal, which may be identified by loss of venous waveform. Correct placement of the catheter tip will help prevent venous erosion and ensure an adequate length of catheter within the vein.

Leakage of infusate at the insertion site suggests extravasation; this may be painful and cause tissue damage. There may be a lack of clinical effect of infusions. Chest X-ray may reveal a migrated catheter, or a pleural effusion. Management of extravasation depends on the nature of the infusate; protocols for extravasation should be followed. Plastic surgical referral may be needed if tissue injury occurs.

Nerve injury

This is uncommon [41]. Peripheral or cranial nerves may be injured. The internal jugular vein is near the brachial plexus and the vagus. The subclavian vein is near the brachial plexus. In the upper arm the median nerve is adjacent to brachial veins and the medial cutaneous nerves of forearms next to the basilic vein. Ultrasound needle guidance should reduce such risks.

Infection control

The recent Michigan-Keystone project in 103 ICUs in the US reported major reductions in central venous catheter (CVC) bloodstream infections from 7.7 to 1.4 per 1000 CVC-patient days [48]. In the UK, the similar 'Matching Michigan' project resulted in a reduction from 3.7 to 1.5 infections per 1000 CVC patient days over 20 months [49]. Recent guidelines provide comprehensive evidence-based recommendations to minimise such infections. Detailed recommendations on catheter selection, insertion site, replacement, removal, management and personal protection can be found elsewhere [50, 51]. Key messages are summarised in Table 2. Anaesthetists should compare their insertion techniques and use of devices with these standards.

Training and experience

Descriptions of the competency levels required for CVC insertion during training and assessment methods are listed in the current Anaesthesia and ICM Curricula (annex F ICM in anaesthesia) (www.rcoa.ac.uk). Competencies for ultrasound guidance have been produced [52].

Current training includes: simulation based teaching (part-task trainers); apprenticeship models; and courses (local/national, basic/advanced).

The Working Party recommends:

- Phantom or manikin simulation techniques should be routinely available to improve novice technique.
- There should regular training updates for skill retention especially for procedures seldom performed (e.g. IO).

Consent and medicolegal aspects

Consent should follow local and national guidelines [53]. Written consent is usual for a standalone procedure or if particular risks are evident. The proposed side and route of access should be explained, as well as the potential need to move to other sites. In practice, much will be verbal as part of a wider discussion of provision of anaesthesia or critical care. Whilst any adverse event may lead to a complaint or litigation, certain serious complications are evident in closed claim analyses highlighted in the complications section [37-39]. Early recognition of the problem, referral to surgery or interventional radiology for help, and correct management of complications is essential for damage limitation.

Use of in-situ long-term devices

Many patients already have such devices in situ e.g. Hickman tunnelled cuffed type, Groschong valved-type, dialysis catheters, peripherally inserted central catheters, and ports. With appropriate infection control, such devices can be used for resuscitation, anaesthesia or critical care. The

risks/benefits of inserting additional CVCs should be assessed. Staff should learn about such devices and stock port access needles (Huber type).

Blood should be aspirated and discarded if concentrated heparin solution locks are in place. Fibrin sleeves may cause obstruction or an extravasation risk. Valved catheters preclude CVC pressure monitoring. Some devices are CT power-injection compatible (e.g. 325 psi rating).

Ultrasound guidance

This has been well covered in the literature. Recent consensus is that where the technology is affordable (e.g. in UK) it should be used routinely for CVCs, and early in other procedures (arterial and peripheral venous), if difficult [35]. Ultrasound makes many steps safer including: evaluation of puncture site; recognition of local pathology; avoidance of the use of seeker needles, needle guidance; verification of guidewire/catheters in a vessel; information on central tip position; and recognition of complications.

Two recent Cochrane analyses [54,55] concluded a benefit for using ultrasound for CVCs by the internal jugular vein, but not femoral or axillary/subclavian routes. The Working party believe the latter is likely to relate to a lack of adequate studies, rather than an inherent failure of ultrasound at other sites, and recommends that ultrasound guidance should be used for all routes of access where the vessel cannot be seen directly or palpated.

Operators need to be adequately trained and experienced, and use a high-resolution device. It takes considerable time and practice to become fully competent in such techniques, and national guidance on training has not quantified this [52].

Technology is developing fast with smaller, cheaper, simpler to use, higher-resolution machines. The efficacy and cost-effectiveness of echogenic needles, electromagnetic sensors, needle guides and other aids is at present unknown and should be a focus for future studies.

In the UK, given the wide availability of ultrasound, the Working Party believe it is not practical for staff to continue to be trained to become fully competent in all CVC landmark techniques. The only situations where ultrasound cannot be consistently used are extensive air emphysema and unavailability of a device in emergencies. An understanding of landmark techniques, is useful for rare occasions when ultrasound is not available or not able to be used. Landmark techniques will still be used in countries where ultrasound is not available.

Service provision for vascular access

The Working Party suggests that all acute hospitals should provide the following for all age groups: local algorithms/guidance for recognition and management of complications; a department/hospital lead clinician to improve procedures, training, documentation and equipment.

Anaesthetists may have a prominent role, but multiple disciplines are involved, depending on the organisation and treatments provided. Services can be nominally divided into acute and elective care as below.

Acute care

Hospitals should organise and provide the following:

1. Timely (24/7) reliable insertion of peripheral venous cannulae in all acute locations. This should not necessarily be the sole responsibility of resident medical staff.
2. Immediate insertion of peripheral IV or intra-osseous access is required in emergencies.
3. Timely (24/7) insertion of peripheral arterial cannula in specialised locations (high-dependency unit, ICU, theatres).
4. Timely (24/7) insertion of short-term CVCs in specialised locations (high-dependency unit, ICU, theatres).

Elective care

5. Hospitals must organise and provide the following: Timely (within 1-3 days) insertion (and removal) of long-term CVCs in specialised locations (wards, theatres, radiology) via a dedicated service. This has been highlighted in the context of total parenteral nutrition administration [4].

All acute hospitals will have requirements for long-term or repeated short-term central venous access, both in the NHS and independent sector. There are varied models dependent on local workload, including: theatre or radiology suite-based, either ad hoc in an acute setting or on separate standalone lists; ward-based models, e.g. nurse-led peripherally-inserted central catheter service.

Facilities needed include: procedure room; high-resolution ultrasound; ECG guidance; fluoroscopy; radiographer; admitting areas; discharge and recovery areas. The cost effectiveness of different models has not been studied in depth. Savings are possible by rationalising services, avoiding treatment delays, failed procedures, and facilitating hospital discharge and outpatient therapy.

Audit

The vascular access lead, and individual practitioners, should initiate regular audit processes to assess compliance with the standards identified in this guidance. Specialist Societies and Colleges should consider national audit to set benchmarks (e.g. the NAP process).

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DRAFT

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Table1. Guide to peripheral cannulation [8-11].

- The smallest practical size of cannula should be used.
- Needle guards to reduce needle stick injury are recommended in all procedures.
- Peripheral insertion is inappropriate for infusion of fluid with high osmolality ($>500\text{mOsm.l}^{-1}$) or low (<5) or high pH (>9) or intravenous access for more than two weeks.
- The relative safety of peripheral administration of vasopressors/inotropes is contentious, but likely to be dependent on vein size and its blood flow, infusion rate, individual drug effect and dilution. This is a good area for future studies.
- Insertion in a limb with lymphoedema should be avoided, except in acute situations due to increased risks of local infection.
- Transillumination, ultrasound and infra-red devices may be useful.
- Routine changes of peripheral cannulae at 72-96 hours is not advocated.
- All cannulae with injection ports must be flushed after use.

Table 2 Principles of infection prevention for vascular access.

For peripheral venous access:

- Thorough hand washing
- Non-sterile gloves
- Skin disinfection with 2% chlorhexidine in 70% alcohol

For peripheral arterial access. As above but this will generally require sterile gloves to allow procedural palpation of the artery, and direct handling of needle, guidewire and catheter.

For central vascular access devices:

- Aseptic hand washing
- Sterile gown, gloves, hat, facemask
- Surface disinfection with 2% chlorhexidine in 70% alcohol (or povidone iodine in those sensitive to chlorhexidine), with air-drying
- Large sterile barrier drapes
- Prefer the upper extremity

Once sited principles follow: appropriate anchorage and dressings, aseptic access techniques; daily site review; and removal at the earliest opportunity.

Table 3. Some features of different central venous catheter (CVC) devices, all suitable for multiple infusions including vein-damaging substances. Adapted from [16, 17]

	Features	Common use	Duration/comments
Non-tunnelled	One to six lumens. Insertion to subclavian, IJV or femoral veins. Some suitable for extra-corporeal treatments.	Short-term CVC. Central venous pressure and SvO ₂ .	Up to 7-10 days. Routine replacement not required.
Tunnelled	One to three lumens. Insertion to subclavian, IJV or femoral veins (entry). Tunnelled to exit site. Dacron cuff anchors device.	Frequent long-term access. Haemodialysis/extracorporeal treatments.	Months/years. Lower infection than non-tunnelled catheters.
Total implanted (Ports)	One to two lumens. Insertion to subclavian, IJV, femoral or upper arm veins (entry). Tunnelled to port.	Frequent long-term access Complex to insert/remove. Uses needle access.	Months/years. Lower infection than tunnelled catheters. Least lifestyle disruption
Peripheral insertion (PICCs)	One to three lumens. Insertion to basilic, cephalic and brachial veins.	Simpler and safer to insert.	One to six months, or longer. Suitable for short term use.

IJV, internal jugular vein; SvO₂, central venous oxygen saturation.

Table 4 Complications of central venous catheter insertion

- Infection
 - Localised or bloodstream.
- Thrombosis / thromboembolism
 - Symptomatic or asymptomatic
- Perforation of vessels and myocardium
 - Arterial puncture / tear
 - Arterial cannulation
 - Venous injury / tear
 - Myocardial perforation / cardiac tamponade.
- Pleural collections.
 - Pneumothorax
 - Haemothorax (haemoperitoneum)
- Cardiac arrhythmias
- Air embolism
- Guidewire/catheter embolism

- Catheter occlusion
- Catheter breakage / leak / extravasation
- Bleeding elsewhere.
- Central venous stenosis
- Neurological injury