Clinical Directive No.: CD085

Peripheral Intravenous Catheter (PIVC) Infection Prevention Clinical Directive

Version No.: 1.1
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Government of South Australia
SA Health

Contents

Peripheral Intravenous Catheter (PIVC) Infection Prevention Clinical Directive

1. Policy Statement

A peripheral intravenous catheter (PIVC) is a device inserted into a person's peripheral vein, allowing for short term intravenous (IV) administration of non-irritating, non-vesicant fluids, blood products and medications. A PIVC provides direct access to the patient's bloodstream and therefore poses a serious risk for infection from microorganisms introduced either at the time of cannulation or while being cared for whilst in situ. Most PIVC related infections are considered to be preventable.

The National Safety and Quality Health Service (NSQHS) Standard 3 requires health service organisations to have processes in place for the appropriate use, management and care of invasive medical devices.

This policy describes evidence-based, best practice principles for the insertion and management of PIVC with a focus on infection prevention. The policy aims to ensure a consistent and standardised approach is taken to manage PIVC throughout SA Health facilities and services. For detailed clinical practice guidance, refer to local health network (LHN) instructions and procedures.

This policy applies to PIVC only and does not address mid-line catheters, umbilical catheters, central venous catheters or any other venous access device.

2. Roles and Responsibility

This Clinical Directive applies to all SA Health staff involved in:

- the insertion and management of PIVC
- writing healthcare facility procedures relating to PIVC
- educating staff and consumers regarding PIVC
- reviewing or selecting PIVC and related products.

Chief Executive:

- ensuring this policy is communicated to and implemented by Heads of all Clinical Units covering all areas of the health service, including both inpatient and outpatient services, where IV catheters are used
- ensuring that health services develop, implement and evaluate local governance procedures, instructions and practices consistent with this policy
- ensuring that all healthcare workers (HCW) who have responsibility for the insertion and management of PIVC are deemed competent and that a register of HCW deemed competent to insert PIVC is maintained by the health service.

Staff

- adhering to this policy
- ensuring they are operating within their scope of practice and competency
- providing consumers with relevant information.

3. Policy Requirements

All SA Health clinical staff must comply with all relevant state and national guidelines relating to the care and management of PIVC to minimise the risk of vascular device associated infection by adhering to the following principles.

3.1. General requirements

- The principles of standard precautions apply at all times including the use of strict adherence to hand hygiene and aseptic technique for all PIVC insertions.
- Healthcare facilities, services and staff must have processes and appropriate governance relating to the use and management of PIVC in accordance with the *Australian Guidelines for the Prevention and Control of Infection in Healthcare*; this includes clinical management (including documentation), appropriate equipment, staff training and competence and partnering with consumers.
- A PIVC must only be inserted if deemed clinically necessary and alternative options are not suitable, e.g. oral medication. If the duration of IV therapy and therefore venous access is likely to exceed six days, then an alternative device such as a mid-line or peripherally inserted central catheter (PICC) should be considered.
- Avoid the unnecessary use of steel needles for the administration of fluids and medication that might cause tissue necrosis if extravasation occurs.
- Taking blood for pathology testing is not an indication for inserting a PIVC. Healthcare workers should not routinely draw blood from a PIVC. Blood can be drawn from a PIVC only if it is in a relatively large vein and only immediately following insertion. For further detail refer to local policy and procedure
  - for neonates and children, refer to LHN policies and procedures regarding collection of blood samples from vascular devices; umbilical catheters are outside of the scope of this document.
- HCW inserting and caring for patients with PIVC must be working within their scope of practice. HCW must be educated regarding the indications for PIVC insertion and management. HCW inserting PIVC must be trained and deemed competent in the insertion technique and understand the principles of preventing IV catheter related infections. A register of staff competent in PIVC insertion should be maintained by the LHN.
- Prior to cannulation, patient identification and consent must be obtained in accordance with SA Health policies, guidelines and LHN procedures.
- Patients must be provided with information regarding the PIVC, care of the device and possible complications. Refer to the Appendices: SA Health PIVC Consumer Fact Sheets (Adult and Children).
- Unless use of an aseptic technique can be confirmed, all PIVC inserted in emergency situations, e.g. during retrieval or cardiac arrest, must be replaced as soon as the patient's condition has stabilised or within 24 hours of insertion.
- All healthcare associated PIVC infections (localised or blood stream infections) must be investigated, reported through the SA Health healthcare associated infection surveillance program and recorded in the Safety Learning System.
- The introduction of new IV devices or components should be monitored by LHNs for adverse events e.g. an increase in the occurrence of device-associated infection.

3.2. Selection of insertion site

- The choice of insertion site is dependent on the patient age and other risk factors.
- In adults preferably use an upper extremity site for catheter insertion; in paediatric patients and neonates the upper or lower extremities or the scalp can be used. Refer to local policies and procedures.

- The basilic or cephalic veins on the posterior (dorsal) forearm (non-dominant forearm if possible) are the preferred insertion site as the stable location reduces PIVC associated complications. Refer to local policies and procedures.

3.3. Skin preparation and disinfection

- Ensure the insertion site is clean and disinfected prior to insertion; if required, clip (do not shave) hair at the insertion site.
- Ensure that any skin preparation is allowed to dry completely before attempting cannulation.
- The use of local anaesthetic should be considered to reduce the discomfort during PIVC insertion. The use of topical anaesthetic agents should be as per the manufacturer's instructions.
- For adults and paediatric patients (>2 months to 16 years of age), disinfect the skin prior to cannulation with 2% chlorhexidine in 70% alcohol solution, except in the case of a documented allergy to chlorhexidine. Refer to the patient's clinician for a suitable alternative.
- For neonates (infants <2 months of age) refer to local LHN procedures. The CDC states "*No recommendation can be made for the safety or efficacy of chlorhexidine in infants aged <2months*".

3.4. Insertion of PIVC

- An aseptic technique that protects key parts and key sites is required for the insertion of all IV catheters. This includes staff strictly complying with hand hygiene practices and the establishment and maintenance of an aseptic field. Sterile gloves are recommended to address the risk of recontamination of the insertion site during re- palpation of the vein or inadvertent contamination of key parts and key sites.
- The insertion site, date, time and the name of the HCW who performed the cannulation must be documented in the patient's medical record. The insertion date should also be documented at the insertion site via a sticker or similar.
- For ultrasound guided PIVC insertion, sterile ultrasound probe covers must be used. Refer to LHN policies and manufacturer's instructions for method of ultrasound device reprocessing.
- After two unsuccessful attempts at cannulation, another skilled and PIVC competent HCW must be consulted. A risk assessment is required to assess further attempts against a delay in treatment, or whether an alternative vascular access device is required. Consider the use of ultrasound guidance to locate veins. A new, sterile catheter must be used for each new attempt.
- Sharps must be disposed of in accordance with relevant AS/NZS Standards and SA Health guidelines.

3.5. PIVC site securement and dressings

- The PIVC must be secured to reduce movement (without applying undue pressure on the skin from the cannula hub) and to reduce the associated risk of phlebitis, catheter migration, dislodgement and migration of skin flora through the percutaneous entry site.
- The PIVC site sterile dressing must allow visualisation of the insertion site. This can be achieved by the use of a sterile, semi-permeable, transparent adhesive dressing.
- Dressings must be replaced if they become damp, non-occlusive, non-adherent, loose, or soiled, if there is excess accumulation of fluid under the dressing or any other indications that compromise the function or integrity of the dressing.
- The PIVC insertion site and dressing must remain dry at all times. Cover the PIVC dressing with an additional waterproof cover when showering or bathing.

- Patients should be assessed for the risk of pressure injury, as per the SA Health Pressure Injury Prevention and Management Guideline. Consider placing a small piece of sterile gauze underneath the hub of the PIVC if the risk of pressure injury has been identified.

3.6. Needleless connectors and access

- When needleless systems are used, a split septum valve may be preferred over some mechanical valves due to increased risk of infection with the latter. All components of the system should be compatible to minimise leaks and breaks.
- The needleless connector should have direct luer access, a direct fluid pathway and neutral displacement. Clinical practices should be appropriate to the type of connector used.
- Prior to each PIVC access, needleless connectors must be disinfected ("scrubbed") for at least 15 seconds with a single-use antiseptic swab and allowed to dry before accessing the system.
- Current evidence suggests 70% isopropyl alcohol should be used to decontaminate the access port or catheter hub. For neonates and children, refer to LHN policies and procedures.
- Where there is an identified or suspected risk associated with the use of chlorhexidine gluconate such as patient allergy or other risk, then an alternative antiseptic agent should be used e.g.70% alcohol or povidone iodine. Consultation regarding risks and recommended antiseptic should occur with the treating medical office and or infectious diseases physician.
- The use of passive disinfection caps on connectors has been reported to help reduce central line associated blood stream infections. There is limited evidence relating to use of these caps for PIVC, however they may be of benefit due to elimination of human error such as omission of recommended practices relating to decontamination of needleless connectors. Manufacturers' recommendations should be consulted to assess chemical compatibility with the connector as part of the decision making process.
- Needleless connectors are only to be accessed with a sterile single use device.
- The needleless connector must be changed using aseptic technique in the following circumstances:
  - if the needleless connector is removed for any reason, or is missing
  - if there is residual blood within the needleless connector
  - if there is drug particulate matter within the needleless connector
  - when contamination is observed or suspected,
  - when clinically indicated.
- Add-on devices (including extension sets) should be luer lock or have an integrated design to ensure a secure connection, reduce manipulation and minimise the risk of disconnection.

3.7. Administration sets

- Replace continuously used administration sets each time a PIVC is re-sited, but at least every 72-96 hours*****.

  *** Note**: Certain infusions require more frequent administration set changes including:
  - when blood, blood products or fat emulsion have been infused, change the administration set including all IV tubing and connections immediately after completion of the infusion or every 12 hours – whichever comes first.
  - for propofol infusions replace tubing every 6 or 12 hours, and when the vial is changed, as per the manufacturer's recommendation.
- Although international literature considers recommendations for replacing intermittently used administration sets an unresolved issue, this policy recommends intermittently used administration sets must be discarded after each single use in accordance with relevant AS/NZS standards.

3.8. Maintenance

- A closed system is to be maintained as much as possible. Administration sets should not be disconnected for routine care e.g. showering/toileting.
- Where disconnection is clinically indicated and unavoidable, aseptic technique must be maintained at all times. If administration sets are disconnected from the IV, the set should be discarded and a new administration set connected using aseptic technique and observing standard precautions.
- The use of passive disinfection caps on needleless connectors to maintain a closed system is not a currently recommended practice.
- Clinicians should replace all fluid administration tubing and connectors when the PIVC is replaced.
- In adults: following administration of medications or fluids, PIVC must be flushed with 5-10mls of sterile 0.9% sodium chloride for injection using a 10ml syringe, using a gentle pulsatile motion.
- In paediatric patients and neonates: refer to LHN procedures.

3.9. Insertion site assessment

- The insertion site must be routinely assessed for signs of infection or other complications:
  - at least every shift / eight hours while the PIVC is in situ and for 48 hours post removal
  - at least hourly for patients who are critically ill, sedated or who have cognitive impairment
  - and prior to each line access.
- Neonate and paediatric patients must be assessed hourly. Refer to LHN procedures for assessment requirements.
- In out of hospital settings such as Hospital in the Home or similar, refer to local policy and procedures for site assessment and management.
- Insertion site assessments must be documented on the appropriate LHN or health service PIVC record form. Refer to SA Health Fact Sheet – Peripheral Intravenous Assessment Score (PIVAS) for assessment guidelines.
- Patients who are receiving an infusion of a vesicant medication or chemotherapeutic agent must be assessed more frequently- refer to LHN procedures.
- Include a visual inspection of the insertion site assessing for redness, swelling, signs of infection or other complications. The site should also be gently palpated through the dressing to determine if there are signs of tenderness, firmness, blanching, moisture, oedema or oozing.
- Consult the patient to assess for pain at the insertion site as part of routine assessment and/or when medications are being administered.
- If infection, phlebitis or extravasation is suspected stop the infusion, implement LHN recommended actions and notify a medical officer immediately. If blood cultures are indicated, collect 2 sets from another peripheral vein. If there is discharge at the insertion site then a wound swab should also be taken.

3.10. PIVC removal

- All PIVC must be removed immediately as soon as no longer required or when complications from the device are suspected or occur. Refer to LHN procedures and instructions for removal procedures.
- Indications for immediate removal of a PIVC include:
  - any level of pain and/or tenderness with or without palpation at the insertion site
  - changes in colour (erythema or blanching) of the insertion site or limb

- changes in skin temperature (hot or cold) at or near the insertion site
- oedema at the insertion site or limb induration
- leakage of fluid or purulent drainage from the insertion site
- other types of dysfunction (e.g. resistance when flushing)
- unexplained fever
- other clinical indication and or order by a medical officer.

3.11. PIVC dwell time and replacement

> PIVC must be removed at the first sign of phlebitis, infection or other complications (see section 3.10) as well as when no longer required.

> For adults, based on analysis of SA Health bloodstream infection surveillance and quality assurance data, as well as current international and national recommendations, it is recommended that PIVC dwell time does not exceed 72 hours, unless certain criteria are met based on a thorough risk assessment (see NHMRC guidelines page 171).

> For neonates and children, refer to LHN policies and procedures. Where neonatal, paediatric and adult services are present in the one facility there may be service specific practices. These must be evidenced based and endorsed by the relevant governance committee.

> Patients transferring from other healthcare facilities and services with a PIVC in situ should have this device assessed by a HCW upon arrival, to determine insertion conditions and dwell time, and the PIVC should be replaced if necessary.

3.12. Post removal care

> The PIVC site should be assessed for at least 48 hours post PIVC removal.

> When the PIVC is removed, patient education must be provided on the signs, symptoms and necessary actions for potential PIVC complications. Ensure the patient has been given a Consumer PIVC Fact Sheet.

4. Implementation and Monitoring

Staff knowledge and adherence to procedures relating to PIVC insertion and management must be monitored on a regular basis (e.g. annually, or more frequently in the case of elevated infection rates) using the SA Health model Peripheral IV Audit tool. Refer to

SA Health Standard 3 – preventing and controlling healthcare associated infection Audit Tools.

Healthcare associated infections secondary to PIVC must be monitored in accordance with SA Health Healthcare Associated Infection Surveillance Policy Directive and LHN procedures. Any observed increase in the rate of PIVC-related infection must be investigated and an action plan developed.

Each PIVC-related infection should be recorded in the Safety Learning System (SLS) for review by the relevant clinical unit. SLS reports should be reviewed regularly by the LHN Infection Prevention and Control Committee.

5. National Safety and Quality Health Service Standards

 National Standard 1 Clinical Governance	 National Standard 2 Partnering with Consumers	 National Standard 3 Preventing & Controlling Healthcare-Associated Infection	 National Standard 4 Medication Safety	 National Standard 5 Comprehensive Care	 National Standard 6 Communicating for Safety	 National Standard 7 Blood Management	 National Standard 8 Recognising & Responding to Acute Deterioration
☒	☐	☒	☐	☐	☐	☐	☐

6. Definitions

In the context of this document:

- **Asepsis means:** freedom from infection or infectious (pathogenic) material.
- **Aseptic field means:** Aseptic fields are important in providing a controlled aseptic work space to help maintain the integrity of key parts and key sites during clinical procedures.

  Examples include:

  - disinfected plastic trays - where key parts can be easily and optimally protected with the use of covers or caps
  - sterile dressing trays - are used when key parts and or key sites (usually due to their size or number), cannot be easily protected at all times with covers and caps, or be handled at all times by a non-touch technique. The size of the aseptic field will be dependent upon the complexity of the procedure to be performed e.g., insertion of CVC, peripherally inserted central catheter (PICC) or complex wound dressings
  - sterile procedure packs – e.g. urinary catheter pack.
- **Aseptic technique means:** Aseptic technique aims to prevent pathogenic micro- organisms from being introduced to susceptible body sites by hands, surfaces and equipment in sufficient quantity to cause infection. It protects patients during invasive clinical procedures by utilising infection prevention measures that minimise the presence of micro-organisms.
- **Bloodstream infection means**: presence of live pathogens in the blood, causing an infection.
- **Disinfection means:** destruction of pathogenic and other kinds of microorganisms by physical or chemical.
- **Extravasation means:** the leakage and spread of blood or fluid from vessels into the surrounding tissues.
- **Fever (pyrexia) means**: a rise in body temperature above the normal i.e. above an oral temperature of 37^{o}C or a rectal temperature of 37.2^{o}C The Centre for Disease Control (CDC) considers a person to have a fever when he or she has a measured temperature of at least 38^{o}C. Fever may be considered to be present if a person has not had a temperature measurement but feels warm to the touch, or gives a history of feeling feverish.
- **Healthcare associated infection means:** an infection acquired in a healthcare facility or which occurs as a result of a healthcare intervention, and which may manifest after people leave the healthcare facility.
- **Healthcare worker means:** any person delivering healthcare services, including students and trainees, who have contact with patients or with blood or body substances.
- **Induration means**: abnormal hardening of a tissue or organ.

- **Key parts means:** key parts are the sterile components of procedure equipment; examples include needleless connectors, needle hubs, syringe tips etc.
- **Key sites means:** key site is any insertion or access site or wound that is connected to, or is part of the patient. Examples include insertion / access sites of intravenous devices, urinary devices, open wounds etc. Key parts and key sites must be identified and protected at all times. Key parts must only come into contact with other key parts and / or key sites.
- **Neutral displacement means:** will not allow fluid to move in either direction when tubing or a syringe is disconnected.
- **Oedema means**: excessive accumulation of fluid in the body tissues.
- **Needleless connector means:** (also referred to as needle-free devices) a connector system developed to help reduce the incidence of needlestick injury while facilitating medication delivery through intravenous catheters.
- **Peripheral intravenous cannula means:** a device usually inserted into a vein of the forearm or hand with length of 7.5cm.
- **Phlebitis means:** inflammation of the wall of a vein.
- **Surveillance means:** an epidemiological practice by which the spread of disease is monitored in order to establish patterns of progression.
- **Vesicant means:** an agent that causes blistering of the skin.

7. Associated Directives / Guidelines & Resources

7.1. SA Policy Directives

- SA Health Hand Hygiene Policy Directive
- SA Health Aseptic technique Policy Directive
- SA Health Healthcare Associated Infection Policy Directive
- SA Health Healthcare Associated Infection Surveillance Policy Directive
- SA Health Clinical Communication and Patient Identification Clinical Directive

7.2. SA Clinical Guidelines

- SA Health Hand Hygiene Clinical Guideline
- SA Health Personal Protective Equipment (PPE) Selection Policy Guideline
- SA Health Consent to Medical Treatment and Health Care Policy Guideline
- SA Health Pressure Injury Guidelines

7.3. References

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frameworks/Public-Health/Mandatory-requirements/Communicable-Disease-Control/Infection-Prevention-and-Control/Insertion-and-Management-of-Peripheral-Intravenous-Cannulae

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7.4. Appendices and supporting resources

- Healthcare Worker Fact Sheet: Peripheral Intravenous Assessment Score (PIVAS) Guide
- Consumer Fact Sheet – Adult Intravenous Cannula (IV Drip)
- Consumer Fact Sheet – Child Intravenous Cannula (IV Drip)

8. Document Ownership & History

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Approval Date	Version	Who approved New/Revised Version	Reason for Change
09/06/20	V1.1	Director, Communicable Disease Control Branch	Align with National Infection Control Guideline terminology and update references
dd/mm/yy	V1	Safety & Quality Strategic Governance Committee (SQSGC)	Original SQSGC approved version.

Fact sheet for healthcare professionals

Peripheral Intravenous Assessment Score (PIVAS)

The patient's peripheral intravenous catheter (PIVC) must be assessed by a healthcare worker to minimise the risk of complications including infection. The frequency of assessment of the PIVC must be at a minimum each time it is accessed and once per shift. Refer to PIVC Clinical Directive for further assessment requirements. Documentation of the PIVAS must be completed each shift on relevant Local Health Network PIVC monitoring charts.

PIVC "Look Listen Feel" Assessment includes

LOOK	LISTEN	FEEL
Observe the PIVC site for erythema, swelling or exudate. Is the dressing clean, dry and intact?	Ask the patient or use visual clues. Is there pain or tenderness on palpation or movement?	Palpate the site through the intact dressing. Is there any heat or vein hardening?

PIVCAS assessment	PIVAS	Recommended Action
No signs of phlebitis or concerns identified from "look, listen, feel" assessment.	**0**	**Continue with standard care.** > Replace dressing if not clean, dry & intact
One of the following is evident: > Pain > Tenderness > Erythema (minor)	**1**	**Consider PIVC removal – inform Doctor** > Review infusion rate and medication > Replace dressing if not clean, dry & intact > Observe patient, continue to record PIVCAS
Two of the following signs or symptoms are evident: > Pain > Erythema > Heat > Swelling > Discharge > Palpable venous cord	**2**	**Remove PIVC immediately - inform Doctor** > Re-site PIVC if required > Document signs and symptoms, PIVCAS and actions in patient records > Complete incident notification > Observe patient and continue to record PIVCAS for at least 48 hours post PIVC removal > Consider blood cultures*
All or some are of the following are evident: > Pain along cannula path > Erythema and/or heat > Induration > Palpable venous cord > Discharge > Pus > Pyrexia	**3**	**Remove PIVC immediately - inform Doctor** > Re-site PIVC if ongoing treatment is required – consider alternative IV access if indicated > Observe patient and PIVC site - document PIVCAS for at least 48 hours post PIVC removal. > Complete incident notification. > Patients discharged from hospital should have GP review. > Consider blood cultures*
* **A PIVAS of 2 or more with associated fever not explained by other causes requires collection of two sets of blood cultures and the PIVC tip sent for culture - consult with Doctor**		

Government of South Australia
SA Health

Other SA Health resources

The following resources can be accessed from:

https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/clinical+resources/clinical+topics/healthcare+associated+infections/indwelling+medical+device+management/vascular+access+device+management

- SA Health Peripheral Intravenous Catheter Infection Prevention Clinical Directive
- Consumer information for adults – Peripheral Intravenous cannula (IV drip)
- Consumer information for children – Peripheral Intravenous cannula (IV drip)
- Aseptic Technique e-learning module, accessed from: https://digitalmedia.sahealth.sa.gov.au/

For more information

Infection Control Service
Communicable Disease Control Branch
Telephone: 1300 232 272
www.sahealth.sa.gov.au/infectionprevention

Public-I1-A1

Version 1.0 (October 2019_

Consumer information (for adults)

Care of your IV drip

What is an IV (intravenous) drip?

An IV drip is a thin sterile **plastic** tube inserted into a vein usually in your arm or hand. It is used to administer fluids and medications. It is also known as a peripheral intravenous cannula.

The IV drip is taped to the skin and covered with a transparent dressing to keep it clean and dry.

A bandage may also be applied.

A board may also be used as a splint to prevent damage to the IV drip from limb movement.

Looking after your IV drip

Your doctor or nurse will be looking after your IV drip. They will monitor the drip at least once each shift and before giving any fluids or medication.

- **Clean** hands - before anybody touches the IV drip they must clean their hands. You can remind health care workers to clean their hands before they touch you.
- **Keep the IV drip dry** - avoid getting the IV drip wet; use an additional waterproof covering when showering**.**
- **Avoid being disconnected from the IV drip** tubing – this may increase the risk of infection.
- **Avoid knocking or pulling on your IV** drip – wear loose clothing and minimal jewellery.

Please **try not to touch** your IV drip, bags of fluid or the IV line – ask your doctor or nurse for help.

Please tell your doctor or nurse immediately if you experience any of the following:

- you feel feverish, have a temperature, feel hot, cold or shivery
- there is pain / redness / heat or swelling near where the IV drip enters your skin
- you see bleeding or leakage from where the drip enters your skin
- the IV drip dressing is wet, falling off or is uncomfortable.

When will your IV drip be removed?

- Your doctor or nurse will decide when your IV drip should be removed when your treatment is finished.
- A new IV drip should be replaced with a new one at least every 3 days, if required.
- After the drip is removed, the site where it was inserted through your skin should be checked for the next 2-3 days for any signs of infection, i.e. pain, redness, swelling or ooze.
- Your IV drip should be removed before you are discharged from hospital, unless your doctor has ordered for it to stay in.

Would you like more information?

- We care about you. Please talk to your nurse or doctor about any concerns you have with your IV drip.

For more information

Hospital telephone: .....

www.sahealth.sa.gov.au/Hospitalinfections

Public-I1-A1

Version 1.0 (September 2019)

This document has been reviewed and endorsed by SQCAG* for consumers and the community –September 2019.

*SA Health Safety and Quality Community Advisory Group

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The IV drip is taped to the skin and covered with a transparent dressing to keep it clean and dry.

A bandage may also be applied.

An arm board may also be used as a splint to prevent damage to the IV drip from limb movement.

Looking of your child's IV drip

Your doctor or nurse will be looking after your child's IV drip. They will monitor the drip at least once each shift and before giving any fluids or medication.

- **Clean hands** - before anybody touches the IV drip they must clean their hands. You can remind health care workers to clean their hands before they touch your child.
- **Keep the IV drip dry** - avoid getting the IV drip wet; use an additional waterproof covering when showering. Avoid placing the IV drip under water i.e. in the bath.
- **Avoid being disconnected from the IV drip tubing** – this may increase the risk of infection.
- **Protect your child's IV from knocks or pulling** – avoid the wearing of tight clothing and jewellery.

Please **try not to touch** your child's IV drip, bags of fluid or the IV line – ask your doctor or nurse for help.

Please tell your doctor or nurse immediately if your child experiences any of the following:

- your child feels feverish, has a temperature, feels hot, cold or shivery
- there is pain / redness / heat or swelling near where the IV drip enters the skin
- you see bleeding or leakage from where the IV drip enters the skin
- the IV drip dressing is wet, falling off or is uncomfortable

the IV drip has stopped, the fluid bag is empty or the drip has fallen out.

Consumer information (for child)

When will your child's IV drip be removed?

- Your child's doctor or nurse will decide when the IV drip should be replaced or removed.
- After the drip is removed, the site where it was inserted through your child's skin should be checked for the next 2-3 days for any signs of infection, i.e. pain, redness, swelling or ooze.
- Your child's IV drip should be removed before you are discharged from hospital, unless their doctor has ordered for it to stay in.

Would you like more information?

We care about your child. Please talk to your nurse or doctor about any concerns associated with your child's IV drip.

For more information

Hospital telephone: .....

www.sahealth.sa.gov.au/Hospitalinfections

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This document has been reviewed and endorsed by SQCAG* for consumers and the community –September 2019.

*SA Health Safety and Quality Community Advisory Group

Government of South Australia

SA Health