

INVASIVE PROCEDURE SAFETY CHECKLIST: Central Line Insertion

BEFORE THE PROCEDURE		
Hands washed by operator and assistant?	Yes	No
2% Chlorhexidine Gluconate / 70% isopropyl alcohol formulation (Chloraprep 2% with tint) applied to procedure site and allowed to dry?	Yes	No
Is all equipment available including ultrasound scanner?	Yes	No
Use a large drape to cover the patient in a sterile manner	Yes	No
Any known drug allergies?	Yes	No

TIME OUT		
Verbal confirmation between team members before start of procedure		
Is patient position optimal?	Yes	No
All team members identified and roles assigned?	Yes	No
Correct line ready (type and size)	Yes	No
Any concerns about procedure?	Yes	No
If you had any concerns about the procedure, how were these mitigated?		

SIGN OUT		
Injection site caps placed using sterile technique	Yes	No
Sterile dressing applied	Yes	No
Guidewire removed?	Yes	No
Chest X-Ray required/ordered?	Yes	No
Any adverse events? (Documented in adverse events Log)	Yes	No

Signature of responsible clinician completing the form	
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Procedure date:		
Time:		
Operator:		
Observer:		
Assistant:		
Level of supervision:	SpR	Consultant
Equipment & trolley prepared:		

Patient Name:	
Hospital Number:	
Date of Birth:	

Record of procedure									
Sterile gloves and sterile gown worn by operator and assistant								Yes	<input type="checkbox"/>
Hat and mask worn by operator and assistant								Yes	<input type="checkbox"/>
Sterile field maintained								Yes	<input type="checkbox"/>
Sterile sheath and sterile gel used with ultrasound probe (if applicable)								Yes	<input type="checkbox"/>
Procedure			Catheter type			Insertion site			
Elective			CVC			Jugular			
Emergency			Vascath			Subclavian			
Re-wire			PICC/ Midline			Femoral			
Ultrasound used?			Catheter length:			Right		Left	
Yes	No	Guidewire Removed				Yes <input type="checkbox"/>			
Venous waveform seen when transduced?		Yes <input type="checkbox"/>				Sutured?		Yes <input type="checkbox"/>	
						No <input type="checkbox"/>			
Complications									
Pneumothorax <input type="checkbox"/>		Arterial puncture <input type="checkbox"/>		Malposition <input type="checkbox"/>		Haemorrhage <input type="checkbox"/>			
2 nd person required <input type="checkbox"/>		Unable to cannulate <input type="checkbox"/>		Other <input type="checkbox"/>		None <input type="checkbox"/>			
Comments and X ray findings:									
Signed:		Name:		Grade:		GMC number:		Date and time:	

Patient Name:

Hospital Number:

Date of Birth: