STANDARD OPERATING PROCEDURE (SOP) W &C Division

Directorate	Paediatric Directorate
Ward/Service	Cystic Fibrosis Service
Title of SOP	Insertion and removal of Non-Coring Needles in Totally Implantable Venous Access Devices (TIVADS often referred to as PORTS)
SOP Number	12
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Date	25th May 2012
Review Date	May 2018

OBJECTIVES	This SOP will describe the process for accessing Portacath/pas-port devices	
SCOPE	This SOP applies to patients diagnosed with Cystic Fibrosis through Clinical Features	
TARGET GROUP	This SOP applies to patients with a diagnosis with Cystic Fibrosis attending the Teesside Cystic Fibrosis Service	
EVIDENCE TO SUPPORT PROCEDURE	The Royal Marsden Manual of Clinical Nursing Procedures Sixth Edition 2005 Yorkshire Cancer Network Guidance for the Management of Central Venous Catheters -5 Guidelines Insertion and Removal of Gripper Needles N.D McIntosh April 2004 GOSH 2009 CVAD Long-term	
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Responsibilities

The following persons have responsibilities within the SOP
Specialist Nurse for Cystic Fibrosis
Nursing Staff with appropriate competencies

Definitions and Abbreviations

Abbreviation	Definition
SOP	Standard operating procedure
CF	Cystic Fibrosis
SpN	Specialist Nurse

Sequence of Clinical Procedure	Rationale/Additional Information
Procedure	
Equipment Needed: Plastic apron, sterile gloves, Dressing pack, 10ml luer lock syringes x 3, Sodium chloride x 10mls Heparin sodium (100 units/ml),x 8mls 70%alcohol 2% chlorhexadine wipes Vygon bionector, (If to be left in situ) Occlusive dressing eg Tegaderm	
1) Explain and discuss the procedure with the child and family	To ensure understanding and gain valid consent
2) If required apply topical anaesthetic cream / Cryogesic spray	To reduce pain sensation on insertion of needle
3) If distraction is required ensure play leaders or an appropriate member of staff will be available to provide distraction during the procedure	To ensure preparation of the child and family prior to the procedure and aid compliance of the child during the procedure
4) Assist the patient into a comfortable position ensuring the port can be easily accessed	
5) Locate the port and identify the septum; assess the depth of the port and the thickness of the skin	To allow correct length of needle to be selected
8) Put on Apron and decontaminate hands using hand soap dry using a clean paper towel	To minimize the risk of contamination
9) Open dressing pack and place all equipment including sterile gloves onto the sterile field utilising a non touch technique	To adhere to infection prevention and control protocol and minimise risk of infection

10) Put on sterile gloves	To minimise the risk of contamination
11) Flush the port needle with 0.9% Sodium Chloride	To check the patency of the needle and remove air
12) Cleanse the skin over the port with clinel wipe utilising an outward spiral motion cleansing as far out as the dressing will be placed repeat twice more. Allow the area to dry completely.	To minimise the risk of contamination and destroy skin flora. To ensure disinfection
13) Holding the needle in the dominant hand locate the port by palpation and stabilise between the forefinger and index finger of the non dominant hand	To ensure the port is stabilised and will not move on insertion of the needle
14) Inform the child that you are about to insert the needle	To prepare the child for a pushing sensation
15) Using a perpendicular angle, push the needle through the skin until the needle hits the back plate	To ensure the needle is well inserted in the portal space
16) Flush with 0.9% Sodium Chloride and observe site and child for any swelling or signs of pain. Stop flush if any of the following occur a) Resistance b) Pain c) Unable to flush d) Swelling e) Leakage of fluid	To check patency and correct positioning and ensure patient safety is maintained
17) Administer the drug as prescribed Following trust policy and the 10 Steps to safer medication	To ensure appropriate treatment is commenced and maintain patient safety
18) Flush with 10mls 0.9% Sodium Chloride	To ensure the child receives the prescribed dose of medication
19a) If needle is to remain in situ, attach a Vygon bionector and flush with 8mls heparin sodium 100 units/ml using a pulsatile flush and clamp the line under positive pressure	To maintain patency
19b) Secure the needle by placing gauze under the needle if necessary and covering with a transparent dressing	To ensure needle is well supported and will not become dislodged and allow for monitoring of the site during future administration of medication
20a) If needle is to be removed Flush with 8mls heparin sodium 100 units/ml clamp under positive pressure	To prevent back flow of blood and possible clot formation
20b) Press down gently but firmly on	To ensure the port is supported whilst

either side of the portal of the implanted port with two fingers	removing the needle
21) Withdraw the needle using steady traction. Discard the needle following trust policy	To prevent trauma to the skin and reduce the risk of needlestick injury
22) It is not usually necessary to apply a dressing to the site but a small plaster may be used	To prevent oozing at the site or due to patient preference
23) Ensure all equipment is disposed of in the correct manner	To ensure safety of staff and patients and uphold trust policy on infection prevention and control and waste management

	AUTHOR TITLE (NAME)	**JOB TITLE**
Developed By:	Fiona Lindsay	Specialist Nurse
	APPROVAL GROUP NAME	**DATE**
Approved By:	Teesside CF Team	25th May 2012