



Documenting a peripheral catheter insertion is a crucial part of the healthcare process, as it helps ensure continuity of care, patient safety, and legal compliance. Here are guidelines to follow when documenting a peripheral catheter insertion:

**1. Date and Time:**

Record the date and time of the catheter insertion procedure. This helps track the catheter's dwell time and facilitates timely replacement.

**2. Indication:**

State the reason for inserting the peripheral catheter, such as administration of medications, fluids, or blood products, or to facilitate blood draws.

**3. Site Selection:**

Specify the site chosen for catheter insertion. Note the location on the patient's body and document the rationale for site selection.

**4. Preparation:**

Describe the steps taken to prepare the patient and the insertion site (e.g., hand hygiene, use of sterile gloves, cleaning the site with an appropriate antiseptic).

**5. Equipment Used:**

List all the equipment used during the procedure, including the catheter size, catheter type, securement device, antiseptic, dressing, and any other relevant materials.

**6. Insertion Procedure:**

Document the process of catheter insertion step by step. Include details such as whether ultrasound guidance was used, the needle size used for cannulation, and any challenges encountered during the procedure.

**7. Flushing and Patency:**

Record the ease of blood return upon cannulation, as well as the success of flushing the catheter to ensure patency.

**8. Patient Tolerance:**

Note the patient's response during the procedure, including any discomfort, pain, or complications encountered.

**9. Securement and Dressing:**

Document how the catheter was secured to the patient's skin and the type of dressing applied. Note any signs of redness, swelling, or infection around the insertion site.

**10. Education and Instructions:**

Mention any education or instructions provided to the patient or their caregiver about catheter care, potential complications, and when to seek medical attention.

**11. Monitoring Plan:**

Include the schedule for monitoring the catheter site, assessing for signs of complications, and planning for catheter removal or replacement.

**12. Signature and Credentials:**

Sign and date the documentation with your full name and professional credentials, indicating that you performed the procedure.

**13. Incident Reporting:**

If any adverse events or complications occur during the catheter insertion, be sure to document them thoroughly and initiate the appropriate incident reporting process.

**14. Follow-up Plan:**

If necessary, outline any follow-up actions required, such as assessing catheter function, monitoring for signs of infection, or scheduling catheter removal.

Remember that documentation should be clear, concise, and objective, avoiding ambiguous language and using standardized medical terminology. Accurate and comprehensive documentation is vital for maintaining patient safety and ensuring effective communication among healthcare providers.