VV CANNULATION CHECKLIST - NURSING

POSITIONING

- ❑ Remove anything in room not necessary for cannulation
- ❑ Bed out from wall
- ❑ Patient toward head of bed and patient right
- ❑ Vent on patient's right side
- ❑ Supine (if prone, do not supinate until otherwise ready to cannulate)

MONITORING

- ❑ Telemetry
- ❑ Radial a-line in place & functional
- ❑ Capnography and pulse-oximetry with QRS audio
- ❑ Defibrillator pads on patient

ACCESS

- ❑ Two large bore IVs or central line access and single large IV
- ❑ All venous lines must be on pumps to avoid air entrainment
- ❑ Long IV tubing and available port for meds
- ❑ Foley with temp probe
- ❑ NGT vs OGT (need to place before anticoagulation)

EQUIPMENT

- ❑ Defibrillator in room
- ❑ Ultrasound in room
- ❑ Bare hugger or heater/cooler in room
- ❑ Console present
- ❑ Backup console present/available

MEDICATIONS

- ❑ Norepinephrine drip
- ❑ Epinephrine
- ❑ Calcium chloride
- ❑ Blood products available with recent T&S
- ❑ Heparin 3000 units (or other anticoagulant) –after MD/DO confirms wires in place
- ❑ Bicarb
- ❑ Plasmalyte or NS free flow
- ❑ Sedation meds and paralytic

PRE-PROCUDURE TIMEOUT

- ❑ Confirm consent on chart
- ❑ Review procedure & indication
- ❑ Review allergies
- ❑ Confirm correct sites
- ❑ Review anticoagulation plan
- ❑ Review roles/participants

POST-CANNULATION

- ❑ Call for CXR
- ❑ ABG, labs
- ❑ Confirm flow/ECMO orders placed
- ❑ Document cannula positions
- ❑ Begin post-procedure monitoring