**Inpatient Cannulation in CT – How Much Scanner Time is Lost?**

**Descriptor:**

This audit will allow quantification of the time lost when inpatients are sent down from the wards without an appropriate cannula in situ.

**Background:**

Cannulation in the CT department for an inpatient may be distressing and can reduce compliance with instructions during the scan. It is better performed by the clinical team caring for the patient on the ward. If there is no CT preparation area for cannulation to be carried out it prolongs the time the patient is on the scan table, which in a busy sevice may compromise throughput with knock on effects on productivity and waiting lists.

## The Cycle

**The standard:**

1. All inpatients arriving for a CT with contrast should have an appropriate cannula in situ.

2. The need for a cannula and the gauge preferred should be specified on the pre CT instructions sent to the ward.

**Target:**

100%

## Assess local practice

**Indicators:**

Presence of appropriate IV cannula.

Documentation to the ward.

**Data items to be collected:**

Data to be collected prospectively.  Departmental staff record details of all inpatients requiring CT scans with contrast.

Details to include

•  Ward they came from.

•  Whether contrast enhanced sequences were specified at the time of vetting before appointment made

•  If there was an appropriate cannula in situ.

• Time taken to insert cannula if one was required.

No appropriate cannula includes: absent cannula, cannula present but not working, looks infected, too small.

**Suggested number:**

Data collection over 2 working weeks – daytime CT lists.

Between 150-200 scans.

**Suggestions for change if target not met:**

•  Reminders to referrers and juniors of the need for a working cannula for inpatients having CT with contrast.

•  Prior to sending down to the department, consider a CT checklist completed by nursing staff which includes assessment of the presence of a working apporpirately sized and sited cannula.

•  Clinical team informed following patient attendance without an appropriate cannula.   If not give the junior doctor responsible for the patient a short time (15 mins) in which to attend the department and site the cannula otherwise the CT is not performed and wasted investigation / hospital stay assigned to the clinical team.

•  Consider dedicated CT preparation room if not already present. This could create a more streamlined service, staffed by a person trained in cannulation. This area could also be used for other procedures such as consent, oral contrast preparation and procedure explanation.

**Resources:**

4 hours data compilation, report writing and presentation.

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