The I-DECIDED® device assessment and decision tool: qualitative findings

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Background	The I-DECIDED® device assessment and decision tool was created from clinical guidelines to facilitate decision-making, with prompts to continue, troubleshoot, or remove a device. In several studies, implementation of I-DECIDED® reduced the prevalence of idle peripheral intravenous catheters (PIVCs) and PIVC complications, and improved nursing documentation.
Aim	To explore nurses' PIVC assessment and decision-making pre- and post-implementation of the I-DECIDED® tool.
Methods	Focus groups with nurses were undertaken during a study to implement the tool in 3 Australian hospitals 2017–2018. Participation was voluntary and informed written consent was obtained. Interviews were audio-recorded and transcribed. Two nurses independently conducted thematic analysis. Ethics approval was obtained.
Findings	**Pre-implementation** (9 focus groups, 54 nurses): Nurses reported assessing PIVC length of dwell and local complications. **Post-implementation** (14 focus groups, 60 nurses): Nurses reported assessing PIVC need; more regular PIVC flushes; more frequent assessment of complications; improved confidence in making decisions about whether to remove the PIVC or change the IV dressing; and improved accountability for documentation. Several nurses said the mnemonic was helpful, but they expressed frustration with the additional paperwork.
Conclusions	Implementation of the I-DECIDED® tool improved nurses' assessment and flushing of PIVCs and increased accountability for PIVC documentation. Nurses reported increased confidence in making decisions to remove unnecessary PIVCs. Electronic records could improve documentation compliance.
References	Ray-Barruel G, et al. BMJ Open. 2018;8(6). http://dx.doi.org/10.1136/bmjopen-2017-021290 Ray-Barruel G, et al. BMJ Open. 2020;10. http://dx.doi.org/10.1136/bmjopen-2019-035239 Ray-Barruel G, et al. International Journal of Nursing Studies. 2023 Sept 9:104604. https://doi.org/10.1016/j.ijnurstu.2023.104604
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Before, if a patient didn't complain about a cannula hurting them or there were no problems with the fluids going through, if it was between days 1–3, maybe I didn't check it as often as I do now. I could probably guarantee it wasn't checked three times a day.

"I have not been nursing for all that long, so I feel like it's a good trigger to get me to remember to check it."

"It's made me think more often about whether they need the cannula."

"Deciding if we need it or can we take it out... Now I know, I am asking on the rounds. Have you got a cannula to come out?"

IDENTIFY if an IV is in situ
If an IV has been removed in past 48 hrs, observe site for post-infusion phlebitis.

DOES patient need the IV?
If not used in past 24 hrs, or unlikely to be used in next 24 hrs, consider removal. Consider change to oral medications.

EFFECTIVE function?
Does the IV infuse and/or flush well? Follow local policy for flushing and locking.

COMPLICATIONS at IV site?
Pain ≥ 2/10, redness > 1cm, swelling > 1cm, discharge, infiltration, extravasation, hardness, palpable cord or purulence.

INFECTION prevention
Hand hygiene, scrub the hub & allow to dry before each IV access. Careful use of administration sets.

DRESSING & securement
Clean, dry, and intact. IV and lines secure.

EDUCATE
Evaluate concerns. Educate as needed. Discuss IV plan with patient & family.

DOCUMENT your decision
Continue to monitor, change dressing/securement or remove IV.

Always consider local policy, and consult with team & patient as required.