

KCMC CANCER CARE CENTER



Patient Name: _____ Diagnosis: _____
 Medical Number: _____ Stage: _____
 Date of Birth: _____ Ward: _____
 Age: _____ Sex: MALE/ FEMALE

Weight (kg): _____ Weight Adjustment: YES / NO
 Height (cm): _____ % of Dose Adjustment _____
 Body Surface (m2): _____ Allergies: _____

DRUG EXTRAVASATION ASSESSMENT TOOL

If extravasation is suspected, the following steps must be followed PRIOR to using this tool:

1. **STOP** the infusion and IV fluids
2. Disconnect tubing from IV cannula. **DO NOT** remove the cannula
3. **ASPIRATE** any residual drug from the IV device with a small (1-3ml) syringe
4. Remove IV cannula
5. Assess site and **Notify Physician!**
6. Initiate appropriate Management according to drug administered.

<p><u>Extravasation Incident</u></p> <p>Date/time of incident: _____</p> <p>Name of drug extravasated: _____</p> <p>Estimated volume of extravasated drug: _____</p> <p>Volume of drug able to aspirate: _____</p>	<p><u>Extravasation Recognized:</u></p> <p><input type="checkbox"/> During Administration</p> <p><input type="checkbox"/> Immediately after administration</p> <p><input type="checkbox"/> Hours after administration: # of hours: _____</p> <p><input type="checkbox"/> Days after administration: # of days: _____</p>
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<p><u>Cannulation:</u></p> <p>Date/Time inserted: _____</p> <p>Place of insertion: _____</p> <p>Difficult Cannulation: Yes/No</p> <p>Number of cannula attempts: _____</p>	<p><u>Type of administration:</u></p> <p><input type="checkbox"/> IV Bolus</p> <p><input type="checkbox"/> IV Infusion</p> <p><input type="checkbox"/> Other: _____</p>	<p><u>Signs and Symptoms:</u></p> <p><input type="checkbox"/> Pain <input type="checkbox"/> Tingling <input type="checkbox"/> Loss of blood return</p> <p><input type="checkbox"/> Swelling <input type="checkbox"/> Erythema <input type="checkbox"/> Ulceration</p> <p><input type="checkbox"/> Leakage <input type="checkbox"/> Infusion slow/stopped</p> <p><input type="checkbox"/> Burning <input type="checkbox"/> Other: _____</p> <p>Color of Skin: _____</p> <p>Measurement of area: _____mm</p>
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<p><u>Immediate Interventions:</u></p> <p>Date/Time: _____ Location where extravasation occurred: _____ Interventions done: _____ _____ _____ ___ Cold Compress ___ Warm Compress For how long? _____</p>	<p><u>Assessment:</u></p> <p>Photo Taken Yes/No</p> <p>Site Marked (outline area of extravasation with marker pen). Yes/No</p> <p>Doctor Notified Yes/No</p> <p>Documented in Patient's File Yes/No</p>	<p><u>Referral and Patient Education:</u></p> <p>Was referral needed? Yes/No To whom? _____</p> <p>Patient Education Done? Yes/No Instructions Given: _____ _____ _____</p> <p>When was patient told to follow-up? _____</p>
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<p><u>Person Performing Assessment:</u> Name _____ Designation _____ Signature _____</p>

EXTRAVASATION ASSESSMENT FLOW CHART:

	Day ____	Day ____	Day ____	Day ____	Day ____	Day ____	Day ____
Date							
Skin Color							
Skin Temp							
Skin Integrity							
Edema							
Mobility							
Pain							
Fever							
Photo							
Signature							

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Grading Scale:	0	1	2	3	4
Skin Color	Normal	Pink	Red	Blanched Centre	Blackened
Skin Temp	Normal	Warm	Hot		
Skin Integrity	Unbroken	Blistered	Superficial Skin Loss	Tissue loss exposing subcutaneous tissue	Tissue loss muscle or bone exposure, deep crater of necrosis
Edema	Absent	Non-pitting	Pitting		
Mobility	Full	Slightly limited	Very limited	Immobile	
Pain	Use scale 0-10				
Fever	Normal	Elevated			

Person Performing Assessment: Name _____ Designation _____ Signature _____
