Peripheral intravenous catheter (IV) are routinely used for vascular access. The unnecessary removal and replacement of a functional IV catheter breaches skin integrity, posing an increased risk of healthcare-associated infection and trauma to patients. This in turn, frequently results in increased length of stay, less than optimal health care outcomes and unnecessary use of health resources.

Evidence suggests there is no significant difference in cases of phlebitis if peripheral IV catheters are replaced only when clinically indicated. Common clinical indications for replacement include phlebitis, infiltration and blockage. Catheter related trauma and infection may also be minimised by vigilant monitoring of the insertion site by health care staff and removal of catheters as soon as it is no longer required.

Imposing unnecessary blood glucose monitoring regimes, that needlessly change a person’s routine, and are random, low frequency or do not provide patients or health care professionals with information that is of value in managing diabetes, will not enhance therapeutic goals.

Glycaemic control is pertinent to the management of Diabetes Mellitus (DM), with self-management a valuable tool in reducing the incidence of complications, improving HbA1c levels*, enhancing quality of life and reducing related health care costs.

The ability to self-care also empowers people and helps to engage them in developing and maintaining behaviours and lifestyle choices that result in improved long-term health outcomes. Blood glucose monitoring should provide feedback relevant to a person’s management plan, including frequency of timing and testing. In addition, unclear or inconsistent monitoring interventions can be needlessly traumatic, may confuse patients and even discourage them from the self-management process.

*The glycosylated haemoglobin (HbA1c) test shows an average blood glucose level over 10-12 weeks.
3. Don’t routinely administer antipyretics with the sole aim of reducing body temperature in undistressed children

Fever is defined as a rise in body temperature above the normal range of approximately 37.8 degrees Celsius and is commonly seen as a primary indication of illness in children. It is a normal physiological response to infection and illness and will not place a generally healthy child at harm.

The benefits of fever in slowing the growth and replication of bacteria and viruses are well documented within the literature, however the administration of pharmacological antipyretic therapy to reduce fever remains a common clinical intervention. Current evidence does not support the routine use of antipyretics solely to reduce body temperature but to maximise the comfort and well-being of the distressed child as an adjunct to the investigation and management of the cause of fever.

Antipyretic therapy is not effective in managing adverse symptoms of fever such as febrile convulsion. Supportive care that includes parental education is also important to increase understanding and to decrease anxiety.

4. Don’t use urinary catheters to manage urinary incontinence unless all other appropriate options have proved to be ineffective or to prevent wound infection or skin breakdown

Urinary tract infections (UTIs) are the most common healthcare associated infection, the majority of which can be associated with the use of indwelling urinary catheters (IDC). Urinary tract infections in hospitalised patients increase morbidity and mortality, antibiotic exposure and often prolong length of hospital stay.

The use of indwelling urinary catheters to manage incontinence is not recommended unless as a last resort or to prevent wound infection or skin breakdown and should be removed as soon as possible.

5. Don’t initiate plain X-ray for foot and ankle trauma unless criteria of the Ottawa Ankle Rules are met

Traumatic injury to the foot and ankle are a common reasons for presentation to the emergency department. The Ottawa Ankle Rules (OAR) are an effective screening tool to guide the use of plain x-ray in the evaluation of these injuries. Validation studies have found that the OARs have an almost 100% sensitivity in many studies in a number of clinical settings. The correct application of the OARs can identify patients who are likely to have a clinically significant fracture and reduce unnecessary use of diagnostic imaging resources by 30-40%.
SUPPORTING EVIDENCE


HOW THIS LIST WAS MADE

The Australian College of Nursing (ACN) as nursing lead, established a collaborative working party incorporating a diverse range of nursing expertise. Professional nursing bodies involved in initial collaboration included: Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM); CRANAplus; Australian Primary Health Care Nurses Association (APNA); Australian College of Mental Health Nurses (ACMHN).

ACN’s membership was consulted via publications, web site and ACN’s National Nursing Forum. This consultation provided a broad view from our members regarding planning and delivery of nursing care across Australia. An interactive session invited delegates to actively participate in identifying those nursing practices, interventions, or tests that evidence shows provide no benefit or may even lead to harm. This informative stimulating session examined a range of nursing practices and their effects on healthcare consumers.

At this point specialist nursing groups were approached for comment on our recommendations. This group included: Australasian College for Infection Prevention and Control (ACIPC); Australian Diabetes Educators Association (ADEA); Continence Nurses Society Australia (CNSA); Australian and New Zealand Urological Nurses Society (ANZUNS); Medical Imaging Nurses Association (MINA); and the Australian and New Zealand Orthopaedic Nurses Association (ANZONA). Final consultation with ACN Members and Fellows prior to submission ensured a collaborative result.

Last reviewed: March 2016