




BMJ Open Peripheral intravenous cannulation decision-making in emergency settings: a qualitative descriptive study

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ABSTRACT

Objectives Rates of unused (‘idle’) peripheral intravenous catheters (PIVCs) are high but can vary per setting. Understanding factors that influence the decision-making of doctors, nurses and paramedics in the emergency setting regarding PIVC insertion, and what factors may modify their decision is essential to identify opportunities to reduce unnecessary cannulations and improve patient-centred outcomes. This study aimed to understand factors associated with clinicians’ decision-making on whether to insert or use a PIVC in the emergency care setting.

Design A qualitative descriptive study using in-depth semistructured interviews and thematic analysis.

Setting Gold Coast, Queensland, Australia, in a large tertiary level emergency department (ED) and local government ambulance service.

Participants Participants recruited were ED clinicians (doctors, nurses) and paramedics who regularly insert PIVCs.

Results From the 15 clinicians interviewed 4 key themes: *knowledge and experience, complicated and multifactorial, convenience, anticipated patient clinical course*, and several subthemes emerged relating to clinician decision-making across all disciplines. The first two themes focused on decision-making to gather data and evidence, such as *knowledge and experience*, and decisions being *complicated and multifactorial*. The remaining two themes related to the actions clinicians took such as *convenience and anticipated patient clinical course*.

Conclusion The decision to insert a PIVC is more complicated than clinicians, administrators and policy-makers may realise. When explored, clinician decisions were multifaceted with many factors influencing the decision to insert a PIVC. In actual practice, clinicians routinely insert PIVCs in most patients as a learnt reflex with little cognitive input. When considering PIVC insertion, more time needs to be devoted to the awareness of: (1) decision-making in the context of the clinician’s own experience, (2) cognitive biases and (3) patient-centred factors. Such awareness will support an appropriate risk assessment which will benefit the patient, clinician and healthcare system.

INTRODUCTION

Billions of peripheral intravenous catheters (PIVCs) are inserted globally every year; they

Strengths and limitations of this study

- This study provides new insights into how emergency care clinicians consider peripheral intravenous catheters (PIVCs) insertion and use.
- Emergency care clinicians from multidisciplinary backgrounds interviewed, including paramedics, doctors and nurses.
- Data collected from a single centre; further themes may have emerged with broader sampling.

are a fundamental part of emergency healthcare.^{1–3} As a result, the PIVC has become an ingrained and ubiquitous part of modern medicine. Clinicians are comfortable with its presence, it has become part of the environment like the patient gown or cubical curtain, in plain sight, yet invisible.⁴ Many of these PIVCs are inserted in the emergency department (ED) or prehospital setting, where patients suffering severe trauma and life-threatening medical emergencies are managed.⁵ The PIVC is a relatively cheap, simple way to manage patients’ symptoms through the administration of analgesics or fluids and improve diagnostic accuracy with the use of intravenous contrast dye.⁵ It is clear the PIVC is an integral part of the modern emergency healthcare system, with many clinicians of different professions possessing varying skill levels for PIVC insertion.⁶

While there are clear benefits, PIVC insertion can be a traumatic and painful procedure for many patients.⁷ First time insertion failure is common, occurring in up to 32% of insertion attempts and is not only distressing for patients, but has been known to result in needle-phobia and hospital avoidance.⁸ A PIVC can pose a serious risk to patients as each insertion breaches the patient’s skin and can act as a conduit for hazardous pathogens to enter the patient’s bloodstream.⁹ Most PIVC complications are associated with



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inflammatory processes such as phlebitis which occurs in 18%–54% of PIVCs insertions.^{10–14}

With the abundant use of PIVCs in the emergency setting, it is likely that many patients are suffering these complications unnecessarily.² Clinicians can perpetuate this with the need or compulsion to intervene and the mindset that doing something is better than doing nothing. However, this may not always be the case.¹⁵ The idle PIVC is a catheter that is inserted and never used; it exposes the patient to avoidable harm, provides no benefit to the patient, and has additional, unnecessary costs for the healthcare system.¹⁶ In the emergency setting, idle PIVCs are common, with up to 50% of PIVCs placed ‘just in case’.¹⁷ An observational study from an ED in Australia reported that one-third of PIVCs inserted did not have a clinical indication.¹⁸ Further, patients requiring an inpatient admission who had a prehospital PIVC were four times more likely to receive an additional PIVC.¹⁸ Previous qualitative research from the USA has highlighted that PIVCs are often the last medical device removed prior to discharge.¹⁹ This study identified several themes around PIVC use insertion and removal centred around ‘knowledge and skills’, ‘organisational policies and practices’, ‘patient centric’, ‘emotional response’, and the ‘expectations of others’.¹⁹

Understanding factors that influence the decision-making of doctors, nurses and paramedics in the emergency setting regarding PIVC insertion, and what factors may modify their decision is essential to identify opportunities to reduce unnecessary cannulations and improve PIVC practices. This is the first Australian study to explore PIVC decision-making among the multidisciplinary emergency care cohort.

Aim

To describe factors associated with clinicians’ decision-making on whether to insert or use a PIVC in the emergency care setting.

METHODS

Design

This research used a qualitative descriptive approach based on the approach by Sandelowski (2010) and Colorafi (2016).^{20 21} Additionally, this research used the Standards for Reporting Qualitative Research guidelines as advocated by the Enhancing the QUALity and Transparency Of health Research Network.²²

Setting

This study was set in the Gold Coast, Queensland, Australia. The population in this region is approximately 570 000 based on the most recent government census.²³ The region has a large tourism focus, based on key tourism events and holiday periods. The area is serviced by a large mixed adult and paediatric tertiary level trauma centre ED, which sees over 110 000 presentations annually. Additionally, prehospital paramedical services are

provided by the local government ambulance service who see approximately 122 000 patients annually.

Population/sample

The population for this study included over 100 medical and 280 nursing staff from the tertiary level ED, and 433 staff from the local ambulance service that were invited to respond. A purposive sample of 15 participants was determined a priori, with potential to interview more if saturation was not reached. This sample was considered an appropriate number of participants to explore the complexity of decision-making relating to PIVC insertion. Five clinicians from each discipline (paramedics, nurses, medical officers) volunteered their interest and participate in this research.

Participant recruitment

A purposive sampling technique with snowballing was used to recruit participants. This was achieved via a group email, sent through normal health service communication distribution lists, inviting participants to be involved in the study. Additionally, posters were placed in the workplace to further distribute the invitation to potential participants. Health professionals who expressed interest in the study were emailed a participant information and consent form. Prior to the interviews, participants completed a written informed consent. In total 9 paramedics, 9 nurses and 12 medical staff responded to the invitation. The first five clinicians from each group who expressed interest participated in the interviews. All 15 agreed and none dropped out or refused to participate.

Data collection

Narratives were obtained from 15 participants between July and September 2020 via individual, one point in time per participant, semistructured interviews. The interview schedule is available as online supplemental figure 1. A trained research assistant (MC) who is an emergency nurse, was supported from a qualitative research expert (JR), who is a qualitative doctoral prepared emergency nurse, conducted the interviews. Researcher JR conducted the first two interviews with MC as an observer. Researcher MC then conducted two interviews with JR as an observer. All further interviews were conducted by MC and reviewed by JR.

The semistructured interview questions were orientated to the research question and informed by existing literature, local experts and results of a recent study regarding PIVC insertion in the prehospital and ED context.²⁴ An interview schedule was created to ensure consistency between interviews.

Due to the COVID-19 pandemic, the planned face-to-face interviews were instead conducted via Microsoft Teams at a mutually agreeable time between the researchers and participants. The interviews were recorded using Microsoft Teams and transcribed verbatim for analysis.

Data analysis

Once transcribed, data were thematically analysed using the six step approach as outlined by Braun and Clarke.²⁵ Three of the authors (HE, JR, MC) concurrently and independently completed the first three steps: familiarisation with the data, generating initial codes and searching for themes. Step four, reviewing themes, was undertaken collectively between three authors (HE, JR, MC). During this step, consensus was reached through detailed conversation and critical questioning resulting in an agreement of the key themes and subthemes. This step identified independently from the three authors that data saturation was achieved from the 15 participants. Step five consisted of a presentation of the main themes and subthemes, with participant exemplars, to the remainder of the research team (GK, NMM, ALS, JB, CMR). During this presentation, research team members were encouraged to critically question the three authors (HE, MC, JE) in defining and naming the themes and subthemes. Minor modifications to the subthemes were made during this step. Finally, step 6, producing the report, occurred during the drafting and writing of this paper. Throughout the research process, the authors were conscious of the various elements of trustworthiness, such as credibility, dependability, conformability, transferability and

authenticity.²⁶ These aspects have been implicitly outlined throughout this methodological section.

Consent to participate

Participation in this research was voluntary. The transcriptions were anonymised, and names replaced with alphanumerical pseudonyms. The alphanumerical pseudonyms represent, D for doctor, N for nurse and P for paramedic, where the number represents the order of interview.

Patient and public involvement

No patients involved.

RESULTS

On average, the level of clinical experience was 11 years with eight males and seven females included. All participants were practising clinicians within the ED or prehospital setting (paramedics). The data analysis revealed four main themes: (1) knowledge and experience, (2) complicated and multifactorial, (3) convenience and (4) anticipated clinical course. Additionally, 32 subthemes were identified under these four themes. The first two main themes relate to gathering data and evidence to inform decision-making, which involved the clinicians'

Table 1 Theme 1: gathering data and evidence: knowledge and experience

Subthemes: **PIVC saves lives, perspectives change with more experience, skills maintenance, using policy and/or protocols, to a point**

Participants stated that on some occasions, they have witnessed timely insertion of PIVCs that have saved lives. On these occasions, the PIVC was integral to the successful management of a patient and interviewees attributed survival to appropriate placement of a PIVC. Therefore, in situations that may be life threatening, PIVCs are inserted.

"... certainly haemorrhaging patients you need large bore access to be able to give the fluids and blood products faster. I've certainly seen patients where that can be lifesaving in my career." (D5)
"... without IV access, she probably, would have seized, and died on the way to hospital." (P5)

As clinicians gain experience and become more comfortable with the procedural competency of PIVC insertion. This experience influences their decisions to insert or not insert a PIVC.

"I guess as you kind of move through a year [of] registrar training, you start to move on to bigger and better procedures. Like the, the victory lap of getting a difficult cannula in probably matters less." (D3)
"... I think I've come to realise when a patient does and doesn't need a cannula ... when I was a grad or whatever you want everybody [to get] a cannula because that was just the way things were done. But as time's progressed not only within myself, but as a culture, I think cannulas are less sort of important..." (N3)

Many clinicians said that they have inserted PIVCs to improve their skills or maintain their skill level. This aspect, combined with clinicians seeing PIVCs as potentially lifesaving, are contributors in their decision to insert cannulas.

"The only way you get good at cannulation is by cannulating people, which means that looking around you for every gun cannulator that's in ED and anaesthetics, there's, you know, thousands of patients that have on a low level been traumatised..." (D3)
"I would have put cannulas in people to keep my skills up." (P2)

Clinicians identified that there are a lack of decision trees or algorithms to help with decision-making and that policy and or protocols guide them, to a point.

"It's too complex to have like a nice, simple algorithm" D3.
"... clinically by looking at the child, but also following State-wide guidelines for that one." D4
"Somebody would have come along and said ... this patient's going to [cardiac] cath lab. If you follow the checklist here partway down the checklist it says two large bore IV cannulas." N3

PIVCs, peripheral intravenous catheters.

Table 2 Theme 2: gathering data and evidence: complicated and multifactorial

Subthemes: **patient-primary complaint and differential diagnosis, needle-phobia, repeat tests, paediatric versus adult, patient expectations; other-time to ED**

Regardless of knowledge and experience, the decision to insert a PIVC is often multifactorial, including patient and other factors such as local policy or environment. The primary complaint and differential diagnoses influenced the decision-making of clinicians, with trauma and cardiac presentations likely to receive a PIVC. Participants described how the limited information and time constraints of emergency medicine can lead to over-cannulation.	<p><i>"Obviously it's about making decisions with limited information in a timely manner. Inevitably that will mean that we over cannulate people."</i> (D5)</p> <p><i>"I know that there's going to be an ongoing ah requirement for pain relief or some type of intervention IV... they're, they're basically the two, two major categories, yes, trauma and cardiac."</i> (P1)</p>
Many clinicians identified that patients with needle-phobias influenced the approach taken by them as emergency care clinicians for this patient cohort.	<p><i>"I had someone ask for nitrous, an adult ask for nitrous, prior to having the cannula inserted, because they'd had such a bad experience in the past, of people attempting, and failing multiple times."</i> (N1)</p> <p><i>"There's probably an argument that we can cause a bit of post-traumatic stress disorder, and pain, especially if we're restraining patients to gain IV access. I'm thinking particularly about mental health patients, and our paediatric patients."</i> (P5)</p>
Clinicians had difficulty in deciding whether phlebotomy or PIVC was the best choice for patients; however, if the patient was likely to require repeat tests, a PIVC was likely to be inserted.	<p><i>"I think venepuncture's easier on the patient and easier to get. Like it's harder to get a nice stable flushing cannula in, than to steal a bit of blood, and you can use a much smaller needle to get blood, so overall I think that venepuncture is easier and probably safer infection wise."</i> (N5)</p> <p><i>"And that's the thing you hate when you do a normal needle stick is, you've mislabelled something or the specimen is haemolysed and all you've done is, a phlebotomy and you come back 15 minutes later and tell the patient that they need another needle."</i> (D3)</p>
Clinicians described giving more thought to placing a PIVC in a child compared with an adult.	<p><i>"I think if we applied the same principles that we do to paediatrics to adults that would probably change our mindsets. We're very happy to stab an adult, whereas we think twice when it comes to a paediatric patient."</i> (D2)</p> <p><i>"...adults, sometimes it's a lot easier to... educate them on the need for the cannula and then they're more accepting of getting one."</i> (N4)</p> <p><i>"Cannulating a paediatric [patient], one, it's traumatising because, you know, they're upset and, and there's a lot of emotion involved, and then two, you're working with little structures."</i> (P1)</p>
It was identified by clinicians that they believe some patients expect a PIVC to be inserted, which adds pressure on the clinician to insert a PIVC.	<p><i>"It's something that we quite frequently do in the emergency department and is almost nearly expected from a lot of people, as part of their treatment, when they come in, is that they need fluids through a drip, or they need medications through the drip, and we probably cave to that more often than we should."</i> (N1)</p> <p><i>"I guess some adults want a cannula. They feel that if they have one, then they must really need to be in hospital as well"</i> (N4)</p>
Prehospital clinicians considered the distance to the ED in their decision-making. Participants describe that patients who are at a considerable distance to hospital are likely to get to a PIVC if they needed interventions. Conversely, paramedics would forgo PIVC insertion even if the patient was critically unwell, yet close to hospital resulting in a short transport time.	<p><i>"Say you're on the other side of [town] and it's a long transport time, then you could justify having multiple attempts and spending time to try and get that cannula in to get that thrombolysis, because in the long run if you can get that in and get the thrombolysis in ... as opposed to someone who you were trying to put one into maybe an anti-emetic and you go, well we could probably just give them a wafer and leave the cannula."</i> (P2)</p> <p><i>"So, patient acuity, and also distance to hospital. They could be really sick, and two min from the hospital, and I'd just happily just deliver them there and say, look, sorry guys [ED doctors and nurses]."</i> (P4)</p>

ED, emergency department; PIVC, peripheral intravenous catheters.

knowledge and experience, and was complex and multifactorial (tables 1 and 2). The other two themes relate to actions clinicians do, associated with decisions of convenience and considering the anticipated clinical course of the patient (tables 3 and 4).

A short description and some participant narrative exemplifying the themes are outlined below. Of note, many of the subthemes and exemplars within these themes are overlapping and interconnected. As such, factors are not independent of one another and occur in a synergistic manner. Further, exemplars are included as representations of the participants' narrative.

Gathering data and evidence

When making a decision to insert or use a PIVC, clinicians use their own knowledge and experience, data which have been accumulated over years of practice. This helps create a 'data bank' of evidence for the clinician consisting of multiple components. The various components that clinicians considered drawing on their knowledge and experience are outlined (see tables 1 and 2).

Undertaking actions

Once clinicians had gathered evidence and data as outlined above, this would then form the basis for the

Table 3 Theme 3: undertaking actions: convenience

 Subtheme: **PIVC equipment at hand, no venepuncture close, allocated bed space**

The insertion of a PIVC can sometimes be related to the convenience of having the appropriate equipment at hand. Clinicians within the ED identified that the lack of phlebotomy equipment contained in vascular access trolleys throughout the ED led to them inserting a PIVC.

Participants based in ED stated that patients would receive a PIVC depending on their allocated bed area. For example, patients in the acute area get a PIVC, as opposed to the minor injuries area.

"If we had the phlebotomy gear on the top of the cannulation trolley so we thought about it, that would be first rather than cannulation first or something." (D4)

"There is a lot of education about (using venepuncture over PIVC] but it's more, I guess, access to the right equipment as well." (N4)

"... any patient that rocks up to ED that gets streamed ... to acute or resus is automatically almost a knee jerk reaction that they get bloods and that's usually via a cannula insertion." (D5)

"...as nurses or doctors, [we] tend to put cannulas in to get bloods. We tend to leave that in and I think that's just a part of the culture with the emergency department and I guess um, I don't know why we do it." (N2)

ED, emergency department; PIVCs, peripheral intravenous catheters.

clinicians' actions regarding PIVC insertion, removal and/or use that was based on convenience and the patient's anticipated clinical course (see [tables 3 and 4](#)).

DISCUSSION

The aim of this research was to describe factors associated with clinicians decision-making on whether to insert or use a PIVC in the emergency care setting. This is the first Australian study to explore PIVC decision-making among this multidisciplinary emergency care cohort.

Within the emergency setting, four main themes that influenced clinician decision-making and actions around PIVC insertion were identified: knowledge and experience, complicated and multifactorial, convenience, anticipated clinical course.

Clinicians' experiences had significant bearing on their decisions for PIVC insertion. Clinicians' could recall more likelihood of PIVC insertion as juniors in comparison to their present clinical level. This reflected various factors, including the importance placed on the procedure; PIVC insertion was seen as a lifesaving intervention and that 'you live and die by vascular access in the ED'. Insertion of a PIVC is one of the first invasive and painful procedures that emergency clinicians perform, and as such there is a degree of hubris with successful PIVC insertion; 'victory laps', 'tally boards' and 'gun cannulators' were all described.

This likely led to clinicians, especially early in their training, inserting PIVCs for practice, or skills maintenance. The maintenance of PIVC insertion skills and the confidence that comes with the procedural competency has previously been reported in a Swedish study as an important factor in successful PIVC insertion.²⁷ However, with time and experience, the pride associated with successful PIVC insertion seems to fade; this may be because it has been replaced with another more advanced skill such as intubation or that the clinician is more aware of the true value and risks associated with PIVCs.²⁸

Decision-making surrounding PIVC insertion is complicated and multifactorial; it is far more complex than most clinicians realise. The dual process theory of decision-making suggests that decisions are made using two distinct pathways. Using system 1, people act instinctively or in line with a learnt reflex that requires very little conscious effort; however, system 2 requires metacognition, engagement and effort.²⁹ Reverting to system 1 is not uncommon in healthcare and this was demonstrated among our participants with most inserting a PIVC as a reflex rather than engaging in a purposeful, critical thought process.³⁰ Patient factors influenced decision-making and the subthemes we identified included the patient's medical history, primary complaint, differential diagnosis, vital signs and having the perception of an unwell versus well patient. Additionally, needle-phobia had a significant impact on clinician decision-making, especially when the patient required blood collection for pathology. There were queries surrounding whether to insert a PIVC when repeated blood draws were required as opposed to using the venepuncture method twice; this was a particularly pertinent consideration for needle-phobic patients and presented as a prominent theme. Blood twice? Our results suggest that most ED clinicians would rather insert one cannula, providing it is successful on the first attempt, rather than perform two venepunctures; however, the common complication of haemolysis resulting from drawing pathology from a PIVC was not discussed by any clinician.³¹ Research from the UK exploring the ongoing care of PIVCs has highlighted that clinicians can have a low risk perception for the impact of PIVC use on patient safety.³² Paramedics' transport time to ED was another factor; paramedics aware of their proximity to hospital would forgo PIVC insertion prior to transport if they were close to hospital. Some patients expected a PIVC to be inserted as it may be perceived as an indicator or marker of how unwell they are and that they are being appropriately cared for; hence placing

Table 4 Theme 4: undertaking actions: anticipated clinical course

Subtheme: **flow/journey—maybe used by others (ambulance to ED, or ED to inpatient), time pressures and patient flow; clinical—medications (analgesia, fluids, etc), better to put one in a well patient, before they become unwell, location and size of cannula**

Emergency care clinicians describe inserting PIVCs based on the anticipated clinical course for the patient. For example, prehospital clinicians will insert PIVCs if it is anticipated that the PIVC will be used in ED and that they are assisting the ED by inserting one. The same was identified by ED clinicians whereby a PIVC would be inserted to smooth the patient journey from the ED to an inpatient unit.

“... when we go through the hospital, what’s their likely pathway? Are they going to be sitting on an ambulance stretcher for two or three hours? I’m thinking that I’m going to add value to the hospital and the patient journey in terms of onwards through the system”. (P1)
“... there’s definitely been sometimes where you’re like, you know, borderline, borderline, oh look, let’s just give them IVs to, to smooth their ride into the hospital.” (D3)

The ED in this setting is extremely busy, the time pressures associated with this workload results in many patients receiving a PIVC, and most likely to reduce the wait time for patients rather than actual clinical needs. Peripheral intravenous cannula insertion is perceived to hasten flow of patients through the ED, even if the device is not required.

“A lot of our staff on arrival time do cannula blood tests because they feel that’s probably really good to get the ball rolling per se.” (D1)
“... with the busyness of our emergency department ... we want everything sorted before they get to the doctor, so that the bloods are back and that the doctor can just see them and that’s I guess(a) faster turnover.” (N2)
“... that seems to be the big driver for cannulas, is just to get patients through quickly”. (D3)

The vast majority of clinicians insert PIVCs with the intention for administration of pain relief, or in patients that could become unwell; however, many are also inserted for the sole purpose of collecting blood samples.

“...we manage pain, with cannulas, which is probably the biggest one, especially pain that can’t be, controlled with paracetamol or other orals, that they [the patient] may have at home. Giving those strong narcotics is, probably the most common thing that we use it for.” (P3)
“... for me it’s [the insertion of a PIVC] the bleeding, severe abdominal pain, respiratory distress, suspected cardiac abnormality, as well as the abnormal haemodynamics, blood pressure, heart rate.” (D2)
“So I guess my main reason for putting cannulas in are probably to get bloods. Unless the patient is obviously sick(then it’s inserted for other reasons too).” (D5)

Emergency clinicians have seen patients deteriorate very quickly and unexpectedly; this in turn leads to them inserting a PIVC even in well patients, as participants describe that it is better to insert a PIVC and not need it, rather than need a PIVC and not have one inserted.

“... so having seen patients go off, deteriorate very quickly, I would always err on the side of caution in those kinds of cases [and insert a PIVC].” (D5)
“If we’re not only looking at analgesia requirements, then yes, I would like to have a cannula in place in case their condition changes, and it becomes harder to establish IV access.” (P5)
“Particularly the more junior doctors who are, you know, they feel it’s almost like a comfort thing when you’re not sure about the acuity of the patient.” (D2)

Clinicians had varying approaches to selecting the size and location of PIVC insertion, with past experiences influencing their decisions. Placing an 18 gauge PIVC in an antecubital fossa was the default choice for most clinicians.

“I also think that we’ve probably been in the situation that you put one somewhere else, their forearm or hand, and then had to replace it later in the cubital fossa for a scan, so then we just learnt to just put in the cubital fossa, without thinking about it.” (D4)
“...as I’ve moved around the [emergency] department in terms of, the different areas and the increase of patient acuity and severity. Picking up a cannula and selecting [the right] gauge is very important.” (N2)

ED, emergency department; PIVCs, peripheral intravenous catheters.

pressure on the clinician to insert a PIVC in potentially clinically inappropriate circumstances. Similar findings to ours have been found in recent literature.¹⁹

Most clinicians would agree that a sick child presents a different set of challenges for the clinicians that care for them. With worried parents and an upset child adding

an extra element of stress, the avoidance of further distressing parents and patients alike via PIVC insertion is highly desirable. This was evident with vastly different decision-making factors for PIVC insertion in adults vs children. Clinicians were more judicious about inserting a PIVC in a child due to the associated stress and trauma

it may cause for both the patient and their parents or guardians. This is a unique perspective as the clinical need for the PIVC is essentially the same for adults and children; however, the paediatric population influenced the clinician into a thought process of avoidance rather than routine insertion.

For our respondents, the PIVC was seen as a device to speed up patient flow through the ED. Time pressures to move patients through the ED were a recurrent theme. ED staff perceived it as easier to manage the patient with a PIVC in place. A PIVC was perceived to provide a safety net in the event of patient deterioration *just in case, to be safe, better to put one in a well patient before they become unwell*. This has precipitated a ‘knee jerk’ reaction around PIVC placement for ED clinicians, with an ‘everyone in ED gets a PIVC’ mentality prevailing. Recent literature suggests that if clinicians think about the probability of the PIVC actually being used, a reduction in the rate of unused PIVCs can be expected; it is likely that if a similar intervention was implemented among this population, it would yield comparable results.^{16 33}

Environmental and cognitive factors also play an important role in the decision-making within the ED *the trolleys at triage are set up for cannulation, not venepuncture*. Clinicians reported that the easiest option was to insert a PIVC rather than to source a phlebotomy kit. These subtle nudges have an impact on decision-making and help reinforce the psychology of system 1.³⁴ For example, a trolley with phlebotomy materials in the top drawer, with PIVCs out of sight would nudge a clinician towards venepuncture.³⁴ Clinicians had clear decision-making for patients that required a PIVC for a specific purpose including the administration of blood products, fluids, antibiotics, analgesia and for pre-empting the use of diagnostic imaging requiring intravenous contrast. This aligns with recent literature examining decision aids for PIVC insertion.¹⁸ For these patients that have an actual need for the device, the nudge is likely to be overridden and the clinician will insert a PIVC that has a high probability of being used.

For paramedics, the limited time spent with patients often means an early judgement call must be made on the patient’s likely clinical trajectory. Similar to ED staff, a *to be safe* approach was used, erring on the side of caution, with paramedics preferring to insert a PIVC in a stable patient, rather than having difficulty trying to insert one in a patient already in extremis. Paramedics also would insert PIVCs in anticipation of the PIVC going on to be used in the ED (most likely for pathology, IV medications or diagnostic imaging).

Our findings draws parallels with other qualitative work carried out in the USA exploring PIVC decision-making.¹⁹ Similar themes of ‘knowledge and skills’, ‘patient-centric’ ‘organisational policies/practices’ and ‘anticipation of clinical needs’ were all reported.¹⁹ This research included mostly nursing staff as participants, with participants not just from the ED but also acute care wards and implies that factors influencing PIVC decision-making may be consistent in different clinical settings and different countries.

Limitations

While this study involved emergency care clinicians from a variety of backgrounds, the sample was from a single centre and may not reflect all emergency centres. Although data saturation was achieved with no new themes emerging, we cannot exclude that if different clinicians with different backgrounds had participated (including less clinical experience, or more quality improvement or academic experience) that this may have led to different themes.

CONCLUSION

The decision to insert a PIVC is more complicated than clinicians, administrators and policy-makers may realise. When explored, clinician decisions were multifaceted with many factors influencing the decision to insert a PIVC. In actual practice, clinicians routinely insert PIVCs in most patients as a learnt reflex with little cognitive input, with the exception of children and needle-phobic patients.

At the time of PIVC insertion, more time needs to be devoted to the awareness of: (1) decision-making in the context of the clinician’s own experience, (2) cognitive biases, and (3) patient-centred factors. Such awareness will support an appropriate risk assessment which will benefit the patient, clinician and healthcare system.

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Contributors HE developed concept, led project, wrote manuscript and is guarantor for this work. MC performed interviews, analysis and assisted with manuscript writing. GK assisted with concept development, manuscript writing and supervision of HE. NMM provided intellectual input, content expertise and assisted with manuscript preparation. ALS assisted with concept development, assisted with

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