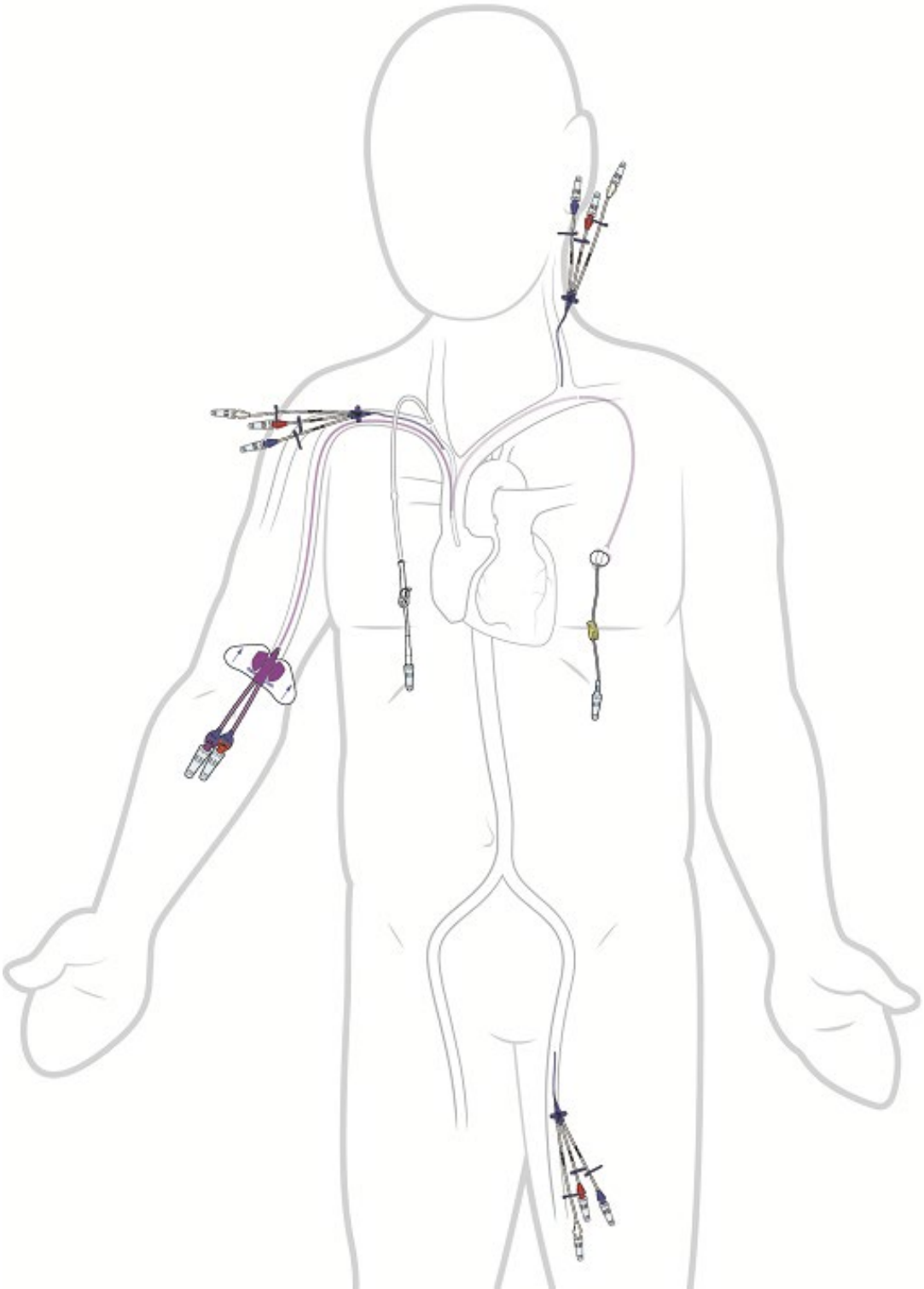
Central Venous Access Devices

Competence Checklists

***Name*_____**

***Department*_____**



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Dressing Change	C = competent
1. Performs hand hygiene, applies non-sterile gloves, surgical mask and appropriate PPE	
2. Prepares sterile supplies including sterile gloves, sterile 10mL normal saline flush x 2, clear connector per lumen, securement device, transparent dressing	
3. Asks patient to turn head opposite direction from CVAD or asks patient to don mask	
4. Removes and discards old dressing, uses alcohol to remove securement device • Avoids tugging on the catheter	
5. Removes and discards non-sterile gloves, Performs hand hygiene.	
6. Cleans the catheter exit site with swabstick, starting at insertion site and working outward in a back and forth friction motion. Repeats the same procedure using a clock formation pattern using additional swabsticks. • Uses final 2 swabs to clean along catheter starting at exit site (1 swabstick for underside of catheter, 1 swabstick for top of catheter) • Does not use both sides of a swabstick to clean; uses new swab stick to clean each side of exit site • Allows site to dry for 30 seconds - DOES **NOT** WIPE OR FAN SITE	
7. Performs hand hygiene, applies sterile gloves using appropriate technique	
8. Applies securement device skin prep to skin where securement device will be applied • Allows to dry • Applies securement device to catheter appropriately, then adheres device to skin	
9. Applies transparent dressing over the exit site and securement device • Avoids tension when applying transparent dressing	
10. Labels new dressing with the date and initial using sticker on transparent dressing	
11. Documents • Date and time procedure completed • Problems encountered and nursing interventions • Dose and time of Saline flush and Heparin (if indicated) on Medication Administration Record	

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Flush	C = competent
1. Scans Saline flush and Heparin lock (if required) to eMAR	
2. Performs hand hygiene, applies non-sterile gloves and appropriate PPE	
3. Cleanses clear connector (injection cap) using friction with 2% chlorhexidine with 70% alcohol swab for 15-30 seconds, and allows to dry • Does NOT wipe or fan site	
4. Connects 10 mL 0.9% normal saline pre-filled syringe to clear connector (injection cap), opens clamp (if present)	
5. Routine Flushing: Aspirates and observes for blood return • *If blood return* noted, flush catheter with 20 mL normal saline (using the turbulent flush technique). • Repeats flushing for each additional lumen	
6. *If unable to aspirate blood* Does not use excessive force to aspirate or flush as this may cause catheter damage or breakage • Asks patient to raise arm over head. • Turns patient onto the side away from nurse • Asks patient to take a deep breath and cough. • Flushes line with 0.9% Sodium Chloride and tries to aspirate again. • Finds out from patient what position works best for him/her. • *If still unable to aspirate blood*, clamps off tubing, notifies the doctor	
7. Follows with Heparin Lock (if indicated)	
8. Following intermittent treatments, flush (using the turbulent flush technique) with 20 mL 0.9% normal saline	
9. Documents • Date and time procedure completed • Problems encountered and nursing interventions • Dose and time of Saline flush and Heparin (if indicated) on Medication Administration Record	

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Flush with Clear Connector (injection cap) Change	C = competent
1. Scans Saline flush and Heparin lock (if required) to eMAR	
2. Performs hand hygiene, applies non-sterile gloves and appropriate PPE	
3. Using aseptic technique, opens clear connector (injection cap) package and primes clear connector (injection cap) with normal saline, keeping syringe attached	
4. If IV tubing is present, stops infusion, clamps tubing, disconnects from the lumen, and applies primed, sterile clear connector (injection cap) to the exposed end • Ensures catheter clamped (if present)	
5. Holds the hub of the catheter below the level of the patient's heart to prevent 'manometer effect' or fluid drop in the catheter and removes the old clear connector (injection cap).	
6. Cleans the outside of the catheter hub with a 2% chlorhexidine with 70% alcohol swab for 15-30 seconds • Allows to dry • Continues to hold outside of catheter to keep from getting contaminated	
7. Removes the top protector from the new clear connector (injection cap) and twists clockwise onto the catheter hub	
8. Unclamps catheter.	
9. <u>Routine Flushing:</u> Aspirates and observes for blood return • *If blood return* noted, flushes all catheters with 20 mL normal saline (using the turbulent flush technique). • Repeat for each additional lumen	
10. *If unable to aspirate blood* Does not use excessive force to aspirate or flush as this may cause catheter damage or breakage • Asks patient to raise arm over head. • Turns patient onto the side away from nurse • Asks patient to take a deep breath and cough. • Flushes line with 0.9% Sodium Chloride and tries to aspirate blood again. • Finds out from patient what position works best for him/her. • *If still unable to aspirate blood*, clamps off tubing • Notifies the doctor	
11. Follows with Heparin lock (if indicated)	
12. Documents • Date and time procedure completed • Problems encountered and nursing interventions • Dose and time of Saline flush and Heparin on Medication Administration Record	

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Obtaining Blood Specimen (For Blood Cultures, see next page)	C = competent
1. Stop all infusions for at least 1 minute prior to blood sampling from CVAD	
2. Performs hand hygiene, applies non-sterile gloves and appropriate PPE	
3. Clamps all lumens of CVAD and intravenous (IV) tubing if present. • If IV tubing is present, disconnects from the lumen and applies primed, sterile clear connector (injection cap) to the exposed end	
4. Cleans clear connector (injection cap) with 2% chlorhexidine with 70% alcohol swab for 15-30 seconds • Allows to dry, do NOT fan or wipe site	
5. Flushes 10-20mL 0.9% sodium chloride to clear connector (injection cap) or lumen hub using "push-pause" technique • Opens clamp (if present) • Confirms patency by aspirating blood without resistance • Aspirates 7 to 10 mL of blood as discard • *If no blood return observed*, repositions patient • If still no blood return observed, flushes with saline and notifies MRP • Does not use excessive force to aspirate or flush	
6. Clamps catheter (if present) and discards syringe with blood.	
7. Using vacutainer or syringe, withdraws blood for testing. • Draws samples in correct order • Uses transfer device to transfer blood from syringe to specimen tube.	
8. Clamps catheter, removes old connector, cleans catheter hub with 2% chlorhexidine with 70% alcohol swab for 15-30 seconds, and allows to dry • Applies new, primed, clear connector (injection cap) to catheter hub.	
9. Opens clamp (if present), and flushes (using turbulent flushing technique) with **two** 10mL syringes 0.9% Sodium Chloride	
10. Reconnects intravenous tubing if prescribed. • Opens all clamps and adjusts flow rate.	
11. *If intravenous therapy is not prescribed*, Heparin Locks if indicated, as per order	
12. Documents • Date and time procedure completed • Problems encountered and nursing interventions • Dose and time of Saline flush and Heparin (if indicated) on Medication Administration Record	

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Obtaining Blood Culture Specimen
• **Able to describe key differences**
  ○ Apply new primed clear connector (injection cap)
  ○ Do not flush line prior to aspirating
  ○ Do not discard sample, first aspiration is the sample to send
	C = competent

1. Stop all infusions for at least 1 minute prior to blood sampling from CVAD	
2. Performs hand hygiene, applies non-sterile gloves and appropriate PPE	
3. Clamps all lumens of CVAD and intravenous (IV) tubing if present. • If IV tubing is present, disconnects from the lumen and applies primed, sterile clear connector (injection cap) to the exposed end	
4. Apply new, primed, clear connector (injection cap).	
5. Cleans clear connector (injection cap) with 2% chlorhexidine with 70% alcohol swab for 15-30 seconds • Allows to dry	
6. Using vacutainer or syringe, withdraws blood for blood cultures • Determines amount required for withdrawal based on blood culture bottles • Draws samples in correct order • Uses transfer device to transfer blood from syringe to specimen tube • Does not flush line with saline or draw discard sample when obtaining sample *If no blood return observed* • Repositions patient • If still no blood return observed, notified MRP • Does not use excessive force to aspirate or flush	
7. Clamps catheter (if present)	
8. Removes old connector, cleans catheter hub with 2% chlorhexidine with 70% alcohol swab for 15-30 seconds, and allows to dry • Applies new, primed, clear connector (injection cap).	
8. Opens clamp (if present), and flushes (using turbulent flushing technique) with two 10mL syringes 0.9% Sodium Chloride,	
9. Reconnects intravenous tubing if prescribed. • Opens all clamps and adjusts flow rate.	
10. *If intravenous therapy is not prescribed*, Heparin Locks if indicated, as per physician order	
11. Documents • Date and time procedure completed • Problems encountered and nursing interventions • Dose and time of Saline flush and Heparin (if indicated) on Medication Administration Record	

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Accessing Implanted Vascular Device (Port)	C = competent
1. Scans Heparin and Saline flush to eMAR • Draws up Heparin 500 units (5mL) in 10mL syringe (if indicated)	
2. Performs hand hygiene, applies non-sterile gloves and appropriate PPE	
3. Positions patient comfortably with head turned away from port or asks patient to don mask. Palpates port site.	
4. Opens sterile glove package, spreads wrapper to create a sterile field.	
5. Places two sterile 10 mL 0.9% Sodium Chloride flushes, non-coring needle, clear connector and transparent dressing onto sterile field	
6. Cleans site with chlorhexidine 2% with 70% alcohol swabstick using a back and forth friction scrub for at least 30 seconds, extending cleansed area up to 10cm diameter. Does not wipe site. Allows 60 seconds to dry.	
7. Performs hand hygiene, applies sterile gloves as per appropriate technique	
8. Primes non-coring needle with extension, with clear connector attached with 10mL 0.9% Sodium Chloride flush, leaving syringe attached and clamps off. • Removes cap cover from needle.	
9. Inserts non-coring needle • Palpates port again with non-dominant hand, stabilizes and feels briefly for diaphragm of port • Picks up non-coring needle with dominant hand, holds needle at 90°, pushes needle through skin and port firmly until the needle hits the bottom of the port chamber • Does not rock or rotate the needle once it has gone through the skin	
10. Opens the clamp and aspirates to check for blood return, • Flushes (using turbulent flush technique) with 10 ml of 0.9% NaCl x 2 • Observes for swelling, discomfort, ease of flushing, quality of blood return	
11. Applies transparent dressing over port site to secure needle	
12. *If unable to aspirate blood*, • Asks patient to raise arm over head • Turns patient onto the side away from nurse • Asks patient to take a deep breath and cough. • Flushes line with 0.9% Sodium Chloride and tries to aspirate blood again. • Finds out from patient what position works best for him/her. • *If still unable to aspirate blood*, flushes line, if possible clamping off tubing • Notifies the doctor immediately.	
13. If accessing for Heparinizing only or intermittent use • Instills Heparin lock 5 mL (100 units/mL), as ordered after saline flush	
14. If connecting to IV infusion Removes syringe, connects IV in an aseptic fashion and opens all clamps	
15. If blood Sampling – (see separate competence)	
16. If removing needle, (see separate competence)	
17. Covers non-coring needle with label including date, and central venous catheter sticker	
18. Secures tubing to chest wall.	
19. Discards all used equipment and repositions the patient if necessary.	
20. Documents • Under GEN IV PORT-A-CATH Site intervention • Date and time procedure completed • Problems encountered and nursing interventions • Dose and time of Saline flush and Heparin (if indicated) on Medication Administration Record	

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De-Accessing Implanted Vascular Device (Port)	C = competent
1. Scans Heparin and saline flush to eMAR • Draws up Heparin 500 units (5mL) in 10mL syringe	
2. Performs hand hygiene, applies non-sterile gloves and appropriate PPE	
3. If IV present, • Closes clamps on non-coring needle and IV tubing • Removes and discards IV tubing	
4. Cleanses clear connector with 2% chlorhexidine with 70% alcohol swab for 30 seconds • Allows to dry	
5. Opens clamp, aspirates and observes for blood return	
6. *If unable to aspirate blood*, • Ask patient to raise arm over head. • Turn patient onto the side away from you. • Asks patient to take a deep breath and cough. • Find out from patient what position works best for him/her. • Repeat step 5 and then Heparin lock port • *If still unable to aspirate blood*, clamp off tubing. notify the doctor	
7. Flushes with 2 x 10 mL 0.9% Sodium Chloride (using the turbulent flush technique),	
8. Instills Heparin lock 5 mL (100 units/mL)	
9. Exposes accessed port site • Removes dressing without dislodging the non-coring needle	
10. To remove needle, • Stabilizes the port by securely holding the base down. • Firmly pulls the textured handle up until the needle is locked • Disposes of needle into sharps container.	
11. Discards all used equipment and repositions the patient if necessary.	
12. Documents • Under GEN IV PORT-A-CATH Site intervention • Date and time procedure completed • Problems encountered and nursing interventions • Dose and time of Saline flush and Heparin on Medication Administration Record	

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Removal of a PICC line	C = competent
1. Explains procedure to the patient and obtains informed consent	
2. Positions patient supine or in Trendelenburg as tolerated to decrease the risk of air embolism	
3. Performs hand hygiene and applies appropriate PPE (mask, non-sterile gloves)	
4. Removes and discards old occlusive dressing	
5. Removes PICC from securement device and uses alcohol swab to loosen the securement device from skin	
6. Removes gloves and performs hand hygiene	
7. Cleans catheter exit site with swabsticks starting at insertion site and working outward in a back and forth friction motion. Cleanses in a clockwise formation pattern using additional swab sticks. • Allows site to dry for 30 seconds	
8. Performs hand hygiene. Applies sterile gloves as per appropriate technique.	
9. Removes the line: • If patient is able, has them perform a Valsalva maneuver or take a deep breath in and hold it. • Uses a hand over hand technique to remove the PICC line in short segments • As PICC is removed, places sterile gauze over site and applies pressure to site for 5 minutes. Applies new sterile gauze to site securing with tape.	
10. *If resistance is encountered during removal:* • Places the patient's arm perpendicular to the body to minimize bends in the catheter and slowly removes catheter. • Avoids direct pressure on the insertion site and catheter tract during removal to help avoid vasospasm • Never pulls against resistance as the risk of catheter breakage, catheter embolism, or vein wall damage could occur. • Notifies physician if resistance persists and does not remove PICC	
10. *If sending catheter tip for culture*, places catheter on sterile field and cuts 10cm from the tip and place in sterile container. Applies patient label to container.	
11. Monitors for signs of bleeding	
12. Teaches patient to observe and report any redness, drainage at the site and/or if febrile.	
13. Documents on the GEN IV PICC Site intervention • Date and time of removal • Location and condition of site • Swab if taken from site • Tip sent for culture if required • Type of dressing applied • Patient's response to procedure	

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