

**PARKLAND HEALTH & HOSPITAL SYSTEM
LEADERSHIP & ORGANIZATIONAL DEVELOPMENT**

COMPETENCY VALIDATION

CENTRAL VENOUS CATHETER (other than PICC) MAINTANENCE AND REMOVAL

Name: _____ ID#: _____

Unit: _____ Date: _____

For study guide refer to Nursing policy NSG 18.06

I. Central Venous Catheter Set-up	1st Attempt (P or F)	2nd Attempt (P or F)	Comments:
1. Verify consent and Perform a Time-Out (can verbalize)			
2. Gather Equipment			
• Central venous catheter kit or subclavian tray			
• Central venous catheter			
• Sterile occlusive dressing and biopatch (as available)			
• Sterile: gown, gloves, sheet, sterile towels			
• Sterile 4 x 4, two packects			
• Chlohexidine preps or betadine (confirm patient is not allergic to betadine)			
• Infusion plugs according to number of central line lumens			
• Pre-filled NS Syringes			
• Syringes are not sterile do not drop onto sterile field; when ready, the physician will direct the nurse to squirt saline into central line tray. Nurse to be careful to not comprise sterile field.			
3. Assist provider as needed (may verbalize)			
4. Monitor patient during procedure (may verbalize)			
5. Post procedure (may verbalize)			
• auscultate breaths sounds			
• order stat chest x-ray			
Do not use line until provider has verified line placement by Chest X-ray and line is cleared for use via physician order			
II. Central Venous Catheter Maintenance	1st Attempt (P or F)	2nd Attempt (P or F)	Comments:
1. Perform hand hygiene and don clean gloves.			
2. Explain procedure to patient			
3. Locate the infusion plug (s) to be flushed.			
4. Prep the infusion plug (s) with alcohol and allow to dry.			
5. Flush per Provider's order and according to unit guidelines.			
6. Dispose of soiled equipment and used supplies.			
7. Remove gloves and performed hand hygiene.			
8. All ports should be flushed at minimum every shift.			
9. Tubing, extension sets, stopcocks, and Micro-clave injection caps must be changed every 72 hours. Dressing should be changed every 7 days or PRN.			
10. Documentation to include			
III. Administration of Medications/Fluid/Blood Products/Lab Draws	1st Attempt (P or F)	2nd Attempt (P or F)	Comments
1. Verify Provider's Order and identify patient using two identifies.			

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2. Gather Supplies			
3. Perform hand hygiene and don clean gloves.			
4. Cleanse clave injection cap with alcohol pad and allow to dry.			
5. Check port to be used for blood return and flush with 10 ml of normal saline.			
6. Access for medication administration: Administer medications, fluids, blood and/or blood components as ordered.			
7. Access for blood draw: Draw 5ml of waste, with new syringe draw blood sample. (if multiple lines, any infusions into other lines should be stopped for >30 seconds before blood draw).			
8. When finished, flush with normal saline using “push-pause” technique. Use 10ml after medications or fluids, use 20ml after delivery of blood and/or blood components or after a blood draw.			
9. Dispose of soiled equipment and used supplies.			
10. Remove gloves and performed hand hygiene.			
11. Document as appropriate.			
IV. Dressing change (Sterile Procedure)	1st Attempt (P or F)	2nd Attempt (P or F)	Comments
1. Gather supplies.			
2. Perform hand hygiene; apply clean gloves.			
3. Place the patient in a comfortable position with arm extended and with head turned away from the catheter site. (may verbalize)			
4. Open first flap of sterile dressing kit and don mask.			
5. Remove the transparent dressing by peeling away from hub toward the securing device and insertion site.			
6. Snap open the cap of each post of the securing device. Lift catheter off the posts. Use alcohol pads to peel securing device away from the catheter insertion site.			
7. Assess the insertion site. Observe for evidence of infection as well as mechanical problems such as kinking or leaks.			
8. Remove gloves, open dressing change kit. Drop Statlock, infusion caps and Biopatch onto the sterile field.			
9. Don sterile gloves.			
10. Clean site vigorously with antimicrobial swab and allow to dry.			
11. Place Biopatch around the site, blue side up, with the slit towards the patient’s head.			
12. Apply skin prep where the Statlock will be placed. Allow to dry.			
13. Slide the securing device under the catheter, so that the notch fits closely around the insertion site, on top of the Biopatch.			
14. Carefully place the wings of the catheter on the posts of the securing device and snap closed.			
15. Position the catheter to avoid any kinks as it enters the insertion site. Hold down one side of the securing device and gently remove the liner on the other side. Press it onto the skin. Repeat for other side.			
16. Redress site using transparent dressing. Apply more occlusive dressings around the primary to ensure the catheter area is secure and sealed.			

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17. Place the strip of foam tape below the lower edge of the dressing, to prevent the catheter from loosening the dressing.			
18. Remove the old infusion caps, scrub the end of the catheter with an alcohol swab and place the new sterile infusion caps.			
19. Flush each lumen per policy.			
20. Label date, time of dressing change and nurse's initials on the outside of the dressing.			
21. Discard supplies. Remove gloves and perform hand hygiene.			
22. Remove gloves and performed hand hygiene.			
23. Document findings and dressing change.			
V. Central Venous Catheter Troubleshooting and Complications (may verbalize)	1st Attempt (P or F)	2nd Attempt (P or F)	Comments:
1. Catheter Occlusion: Resistance felt when flushing or fluid will not flow into catheter (may verbalize) <ul style="list-style-type: none"> • Do not force flushing solution • Check catheter for kinking at insertion site • Call Provider 			
2. Dislodgement of catheter <ul style="list-style-type: none"> • Turn all IV fluids off • For partial dislodgement of central line, cover fully with sterile 4x4's and secure • Notify provider • Never reinsert catheter • PSN must be entered for all catheter dislodgements 			
3. Catheter disconnection <ul style="list-style-type: none"> • Reconnect/occlude the open catheter • Call for assistance • Check vital signs • Observe for restlessness, chest pain, hypertension, cyanosis, dyspnea, tachycardia, tachypnea, syncope, wheezing • If appropriate, place the patient on the left side in Trendelenberg position • Notify provider with findings • Oxygen as ordered 			
4. Pain, edema, redness, and/or drainage at insertion site, catheter leakage or migration should be assessed, documented and the provider notified			
5. Leakage of IV fluid/blood from catheter <ul style="list-style-type: none"> • Assess all connections in place and secure • Verify integrity of clave injection cap 			
6. Extremity swelling: Notify provider immediately and document in nurses notes.			
7. Bleeding from insertion site <ul style="list-style-type: none"> • Reinforce dressing • Once bleeding stops change dressing • If bleeding is new or persists notify provider • Document all findings and actions 			

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8. Assess, document and report to provider complications: <ul style="list-style-type: none"> • Sudden onset of shortness of breath or chest pain • Assess patient vital signs • Notify provider • Document findings, nursing actions 			
VII. NON-PICC Central Venous Line Removal	1st Attempt (P or F)	2nd Attempt (P or F)	Comments
1. Verify Provider's Order; identify patient by using patient's name and Medical record number. (may verbalize)			
2. Explain procedure to patient. (may verbalize)			
3. Wash hands (may verbalize).			
4. Turn off all infusions and clamp all ports.			
5. Place the patient in Trendelenburg position or supine position.			
6. Don gloves and remove dressing.			
7. Inspect site for redness, pain, swelling exudates or other problems. (may verbalize)			
8. Don sterile gloves and cleanse site with Chlorhexidine or providine-iodine.			
9. Remove sutures (being careful not to cut catheter).			
10. Have patient perform Valsalva maneuver or hold breath to decrease risk of air embolism during catheter removal. If patient is receiving mechanical ventilation, remove catheter during expiration (may verbalize)			
11. Remove catheter with a steady, gentle motion. If resistance is met, stop removal process and notify provider.			
12. Following removal, with 4X4, apply firm pressure to site for a minimum of 5 minutes. <ul style="list-style-type: none"> • Additional time may be required if receiving anticoagulants or patient with coagulopathies. (may verbalize) 			
13. Once bleeding has stopped, immediately apply antiseptic ointment to occlude site and cover with an occlusive dressing.			
14. Inspect catheter length and integrity of catheter.			
15. If culture ordered, do not allow tip of catheter to touch any non-sterile surfaces, cut catheter tip with sterile suture scissors. Place catheter tip in sterile container at bedside and send to the Microbiology laboratory within 30min. Match label to armband and requisition.			
16. Document date/time of catheter removal, observations, actions, tolerance to procedure and patient teaching. (may verbalize)			
17. Change dressing and assess site for signs of infection every 24 hours until healed (may verbalize).			
18. Continue to assess patient for complications (may verbalize).			

The completion of this form validates the above nurse's competency for this skill.

#1 Pass / Fail Competency Validator Signature: _____

#2 Pass / Fail Competency Validator Signature: _____