

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

**COMPETENCY VALIDATION
PERIPHERALLY INSERTED CENTRAL CATHETER CARE**

Name: _____ ID#: _____

Unit: _____ Date: _____

Maintenance of a PICC when not in use	1st Attempt (P or F)	2nd Attempt (P or F)	Comments
1. Gather Supplies			
2. Perform hand hygiene and don clean gloves.			
3. Cleanse all clave injection caps with alcohol pad and allow to dry			
4. Check each port for blood return and flush each with 10 ml normal saline using "push-pause" technique.			
5. Non-valved Catheter (has clamps): Inject 2 ml heparin flush (100 units/ml) with a 10 ml syringe and clamp using positive pressure technique.			
6. Valved Catheter (no clamps): No need for further flush			
7. Disposed of soiled equipment and used supplies.			
8. Removed gloves and performed hand hygiene.			
9. Only syringes ≥ 5 ml should be used on PICCs (best is 10 ml)			
10. All ports should be capped with blue micro-clave injection caps			
11. All ports should be flushed at minimum every shift.			
12. Tubing, extension sets, stopcocks, and Micro-clave injection caps must be changed every 72 hours. Dressing should be changed every 7 days or PRN.			
Accessing a PICC (for medication administration or blood draw)	1st Attempt (P or F)	2nd Attempt (P or F)	Comments
13. Verify Provider's Order and identify patient using two identifies.			
14. Gather Supplies			
15. Perform hand hygiene and don clean gloves.			
16. Cleanse clave injection cap with alcohol pad and allow to dry			
17. Check port to be used for blood return and flush with 10 ml of normal saline			
18. Access for medication administration: Administer medications, fluids, blood and/or blood components as ordered			
19. 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)			
20. 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.			
21. For non-valved catheters, follow with 2 ml of Heparin flush (100units/ml) in a 10ml syringe.			
22. Disposed of soiled equipment and used supplies.			
23. Removed gloves and performed hand hygiene.			
24. Document as appropriate			
Dressing change (Sterile Procedure)	1st Attempt (P or F)	2nd Attempt (P or F)	Comments
25. Gather supplies			
26. Perform hand hygiene; apply clean gloves.			
27. Place the patient in a comfortable position with arm extended and with head turned away from the catheter site.			

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28. Open first flap of sterile dressing kit and don mask.			
29. Remove the transparent dressing by peeling away from hub toward the securing device and insertion site.			
30. 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.			
31. Assess the insertion site. Observe for evidence of infection as well as mechanical problems such as kinking or leaks.			
32. Remove clean gloves, open dressing change kit. Drop statlock, infusion caps and biopatch onto the sterile field.			
33. Don sterile gloves.			
34. Clean site vigorously with antimicrobial swab and allow to dry.			
35. Place the biopatch around the site, blue side up, with the slit towards the patient's head.			
36. Apply skin prep where the statlock will be placed. Allow to dry.			
37. Slide the securing device under the catheter, so that the notch fits closely around the insertion site, on top of the biopatch.			
38. Carefully place the wings of the catheter on the posts of the securing device and snap closed.			
39. 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.			
40. Redress site using transparent dressing. Apply more occlusive dressings around the primary to ensure the catheter area is secure and sealed.			
41. Place the strip of foam tape below the lower edge of the dressing, to prevent the catheter from loosening the dressing.			
42. Remove the old infusion caps, scrub the end of the catheter with an alcohol swab and place the new sterile infusion caps.			
43. Flush each lumen per policy.			
44. Label date, time of dressing change and nurse's initials on the outside of the dressing.			
45. Discard supplies. Remove gloves and perform hand hygiene.			
46. Removed gloves and performed hand hygiene.			
47. Document findings and dressing change.			
Miscellaneous	1st Attempt (P or F)	2nd Attempt (P or F)	Comments
48. Pain, edema, redness, and/or drainage at insertion site, catheter leakage or migration should be assessed, documented and communicated to the PICC team and the provider.			
49. A PSN must be entered for all catheter dislodgement NEVER attempt to re-insert the catheter.			
50. See Nursing Procedure NSG 18-02 for specific trouble shooting and patient discharge planning.			
51. Only PICC team nurses and Provider's can remove PICC lines.			
52. PICC team is contacted by pager via the Parkland Directory "On Call Search" PICC consult.			

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: _____