CENTRAL VENOUS ACCESS DEVICE
Student Reference Guide
WEST COAST UNIVERSITY

NPSG	Wash hands per CDC guidelines. ➢ ***Verbalize 20 seconds per CDC handwashing guidelines.***
	Provide patient privacy. ➢ Verbalize and physically demonstrate.
NPSG	Introduce yourself.
NPSG	Identify patient correctly using two identifiers (check to chart). ➢ Patient's name and date of birth.
NPSG	Verify allergy status.
	Perform environmental safety check.
	Ensure proper body mechanics.
NPSG	Gather all supplies, equipment, and PPE as needed.
	Verify MD order. Assess for procedure need. Explain the procedure and educate the patient.

GENERAL SURVEY

Note site condition and appearance.
Check for any indicators of infection: erythema, warmth, swelling, tenderness, discharge. ➢ *MUST verbalize assessment of the site condition.*

IMPLANTED PORT

ACCESSING CENTRAL SITE
Don gloves and mask. Ask patient to turn head. Put mask on patient.
Palpate and inspect skin over and around port. Apply topical anesthetic if needed.
Remove gloves and perform hand hygiene.
Prime and prepare access cap, extension tubing, and non-coring needle with prefilled saline syringe. Keep syringe attached to access cap and place on sterile field.
Open sterile dressing change kit and don sterile gloves. ☆ **If sterile technique is broken, please verbalize that you have broken sterile technique to restart the procedure. You are given once chance to recognize any breaks in sterility.** ➢ ***Multiple and ongoing*** **breaks in sterile technique will result in failure to execute the procedure.**
Cleanse site with antiseptic and allow to dry. Immobilize device with nondominant hand. With dominant hand, insert primed needle into port at 90^0 angle. Push firmly through skin until needle hits back of port.
Pull back slightly on syringe plunger to check for brisk blood return. Flush with normal saline from syringe attached to injection cap and extension tubing. ☆ **Always aspirate for blood return with central lines when checking for placement.** ➢ ***Central lines are all flushed via pulsatile method.***
Cover device with sterile transparent dressing. Secure extension tubing in place with tape. Remove syringe using positive pressure flushing technique.
If deaccessing port, heparinize line before removing noncoring needle.
Label site.

NPSG	Dispose of soiled supplies in biohazard bag.
Safe Environment	Ensure a safe environment returning bed to lowest height with brakes locked and appropriate side rails up, and call light/bell in reach.
NPSG	Wash hands per CDC guidelines.

DISCLAIMER: THIS DOCUMENT SERVES AS A REFERENCE GUIDE AND IS NOT THE OFFICIAL VALIDATION CHECKLIST.

CENTRAL VENOUS ACCESS DEVICE STUDENT REFERENCE GUIDE

OBTAINING BLOOD SAMPLE
Assess site condition check for indication of infection.
Temporarily turn off any infusing solutions. Disconnect IV tubing from access port.
Clean access port and injection cap with antiseptic and allow to dry.
Connect saline filled syringe to appropriate lumen. Withdraw blood until it reaches syringe but does not enter into syringe. Flush line with normal saline in 10 ml or larger syringe. Using same syringe, aspirate and withdraw blood to discard. ➢ **Always withdraw the amount that you flushed the line with. This will vary according to hospital policy. For WCU skills lab, you may flush and withdraw at *LEAST* 5 mL**
Attach a new, 10 mL sterile syringe to extension tubing. Withdraw blood sample. Remove syringe from extension tubing holder.
Attach blood transfer device to syringe. Fill blood tubes and set aside. Discard blood transfer device in the biohazard sharps container.
Flush line with 10 ml normal saline using pulsatile flush method. Clamp tubing. Discard in biohazard sharps container.
Connect new access cap (if appropriate), connect IV tubing to extension tube.
Label specimen (time, date, initials, site), place in biohazard bag, send to laboratory.

INITIATING AN INFUSION
Perform 6 rights of medication administration. ➢ **Verbalize six rights of medication administration per ATI.**
Wipe access port with antiseptic pad and allow it to dry. Attach prefilled saline syringe to access port. Open clamp and aspirate for blood flash or blood return.
Flush line with required amount of fluid in 10 mL or larger syringe using pulsatile flush method. Maintain positive pressure when withdrawing syringe.
Swab port with antiseptic pad, allow to dry and attach IV tubing and administer infusion.

DISCONTINUING AN INFUSION
Turn off infusion pump. Clamp extension tubing.
Disconnect IV tubing from access port. Place sterile cap on end of tubing.
Clean access port and injection port with antiseptic and allow to dry. Flush line with Normal Saline. Clamp tubing.

DEACCESSING THE SITE
Prepare supplies.
Don clean gloves, palpate and inspect skin over and around port.
Open clamp on extension tubing. Cleanse access cap with antiseptic. Attach prefilled 10 mL saline syringe to access cap.
Aspirate for blood flash. Withdraw blood until it reaches but does not enter into syringe.
Flush line with normal saline, using pulsatile flush method. If port requires heparinization, attach labeled heparin syringe to access cap of clamped extension tubing, and flush line.
Loosen and remove all dressings stabilizing and covering noncoring Huber needle device. Use thumb and index finger of nondominant hand to stabilize device. Use dominant hand to remove Huber needle with upward pull to engage needle's safety feature.
Apply pressure with sterile gauze if bleeding.

PERIPHERALLY INSERTED CENTRAL CATHETER (PICC) CARE

OBTAINING A BLOOD SAMPLE
Raise height of bed and lower head of bed.
Don clean gloves and temporarily turn off any infusing solutions. Clamp all lumens not used for drawing blood.
Inspect and palpate around insertion site for swelling or tenderness.
Using friction, clean access port and injection cap with antiseptic, then allow to dry.
Connect saline filled syringe to appropriate lumen. Withdraw blood until it reaches syringe but does not enter into syringe. Flush line with normal saline in 10 ml or larger syringe.
Using same syringe, aspirate and withdraw blood to discard. Attach another syringe to extension tubing. Withdraw blood sample. Remove syringe from extension tubing holder.
Discard initial specimen in a biohazard container. Place new sterile injection hub on access cap. Flush catheter using pulsatile flush method. Clamp tubing and remove syringe. Fill blood tubes and resume infusions.

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DRESSING CHANGE
Assemble supplies prior to entering the room.
Don clean gloves and mask.
Ask patient to turn head away from insertion site. Provide patient with a mask. ➢ ***MUST* physically provide a mask to the patient (and yourself) when performing a dressing change to prevent CLABSI.**
Inspect and palpate site around dressing for swelling or tenderness.
With clean gloves, remove dressing by pulling it toward catheter's insertion site. When removing transparent dressing, grasp opposite sides, pull outward, and stretch it away from insertion site. Remove anti-microbial patch. ➢ ***MUST* verbalize site assessment.** ☆ **When removing dressing, lift the edge of dressing and remove towards the insertion site to prevent migration of the central line.**
Assess site and examine catheter and hub. Measure external portion of catheter. Compare to previous length to detect migration. ➢ ***MUST* verbalize comparison with current external portion of catheter to what was previously documented on the patient's electronic chart.** ➢ ***MUST* verbalize "no migration noted."**
Remove gloves, discard dressing and gloves.
Perform hand hygiene.
Open sterile dressing kit and don sterile gloves. ☆ **If sterile technique is broken, please verbalize that you have broken sterile technique to restart the procedure. You are given once chance to recognize any breaks in sterility.** ➢ ***Multiple and ongoing* breaks in sterile technique will result in failure to execute the procedure.**
➢ Cleanse insertion site. Cleanse skin under central line and up line. Allow to air dry. Apply skin prep. Apply anti-microbial patch. Apply transparent dressing. ➢ ***FIRST, cleanse with alcohol in a circular motion for at least 30 seconds.*** ➢ ***SECOND, cleanse the site with CHG in a back and forth motion for at least 30 seconds.*** ➢ ***THIRD, cleanse central line with a new CHG swab from insertion site upwards.*** ➢ ***APPLY skin barrier cream where the transparent dressing will be applied (not on insertion site).*** ➢ ***When applying the (antimicrobial patch) biopatch, remember that the blue portion faces up. Place the biopatch slit radial to the central line to help facilitate future removal.*** ☆ **Remember that the biopatch does not come in the sterile dressing change kit, which means you will need to place it into your sterile field via sterile technique. Points will be deducted if sterility is broken.**
Coil external portion of catheter and tape in place.

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Revision: Colletti, Costea & Nguyen, 2020