PIONEER MEDICAL CENTER
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POLICY and PROCEDURE		
Title	Peripherally Inserted Central Catheter (PICC) Care	
Manuals	CAH-PCIV	
Approved By	Date: 01/21/2015 By: Erik Wood Title CEO	

Policy Statement

Patients with a peripherally inserted central catheter (PICC) will be cared for in a safe and consistent manner.

Intent

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Provide guidelines and instructions in the management of the PICC.

Definition

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A Peripherally Inserted Central Catheter (PICC) is a soft flexible catheter that is inserted in the upper arm with the distal tip in the superior vena cava. The PICC may be used to deliver irritating, hyper-osmolar, vesicant or chemotherapeutic agents, and for long term IV medication or difficult IV access needs of the patient. A PICC may remain in place for 1-2 years. It is usually placed in radiology.

Procedure

General Considerations

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1. RNs manage and care for PICC catheters.
2. LPNs that have demonstrated competency may perform a dressing change.
3. Measure the arm circumference 3 inches above the insertion site upon insertion and every AM and documentation is part of the ongoing assessment for potential complications involving phlebitis and thrombus formation.

Potential Complications of PICCs

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Phlebitis
Myocardia damage/arrhythmias
Nerve damage
Bleeding/hematoma
Thrombosis
Catheter migration/embolus
Infection/catheter related sepsis
Hemo/pneumothorax

In the event of infection, phlebitis or thrombus formation

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1. In the event of infection, phlebitis or thrombus formation, all catheters in place must be considered as potential source of the complication.
2. Collaboration with the provider is required.
3. Heat may help resolve vein irritation due to PICC insertion. A thermo-controlled warming pad may be wrapped around the upper arm.
4. Observe for 24-hours and if improvement is noted, continue for up to 72 hours.
5. Patient should be encouraged to use accessed arm as much as possible. This will ensure good blood flow and reduce the potential of phlebitis. Heavy and strenuous activity should be avoided.

Changing tubing, cap and dressing	**Changing tubing, cap and dressing** 1. Keep the arm below the level of the heart when changing tubing(s) or injection cap(s) and dressing change/site care. 2. Tubing and injection cap are to be changed every 96 hours and dressings every 7 days or prn.
Tourniquets and blood pressure cuffs	**Tourniquets and blood pressure cuffs** 1. Tourniquets and blood pressure cuffs should be avoided on the PICC arm if all possible.
PICC removal	**PICC removal** 1. A provider order is required to remove a PICC and may be removed by a Registered Nurse. 2. When removing, do not stretch catheter tubing because excessive tension can cause catheter rupture or separation.
Accessing and flushing PICC	**Accessing and flushing PICC** 1. When accessing or prior to flushing or injecting medications/solutions must confirm patency by aspirating for a blood return, and if present, flush; if no blood return further assessment (may need to be declotted, see….) 2. Obtains supplies (alcohol pads and saline flush, heparin flush, gloves) 3. Perform hand hygiene 4. Scrub injection cap vigorously with alcohol pad and allow to dry. 5. Connects syringe with saline to the injection cap and confirms patency by aspirating for a blood return. 6. Flush with 10mL of normal saline using push-pause method 7. Flush with 10 unit/mL Heparin (2mL with extension tubing, 1 mL without tubing) using push-pause method.
Medication Administration	**Medication Administration** 1. Clean injection cap with alcohol pad and confirms patency by aspirating for a blood return. 2. Flush with 10 mL normal saline using push-pause method. 3. Administers medication. 4. Flush with normal saline and heparin per protocol (see above flushing) using push-pause method.
Laboratory Draws	**Laboratory Draws** 1. Obtain supplies (alcohol pads, normal saline, empty syringe for blood collection, heparin flush, exam gloves). 2. Perform patient identification. 3. Perform hand hygiene. 4. Don gloves. 5. If patient receiving fluids, medications via IV pump, turn to hold. 6. Scrub injection cap with alcohol pad and let dry. 7. Connect syringe with saline to injection cap and confirms patency and flush 10mL of normal saline using push-pause method (If patient receiving TPN, flush with 20mL of normal saline). 8. Waste 10 mL of blood and discard. 9. Attach empty syringe and withdraws required amount of blood for sample. Remove syringe. 10. Clean injection cap with alcohol pad to remove blood, allow to dry 11. Flush with 10mL of normal saline using push-pause method 12. Resume IV fluids as ordered or flushes with Heparin per protocol using push-pause method
For blood cultures:	**For blood cultures:** 1. Two specimens must be obtained from different sites. 2. One specimen must come from the suspicious line that is determined by the provider. 3. Follow steps outlined in “Laboratory Draws”.

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Changing injection cap(s) and extension tubing	**Changing injection cap(s) and extension tubing** 1. Maintain cap sterility during procedure. 2. Obtain needed supplies (alcohol pads, injection cap, extension tubing, syringe, normal saline flush, gloves). 3. Perform hand hygiene. 4. Attach injection cap/extension tubing and flushes with 10mL of normal saline. 5. PICC injection cap/extension tubing are changed every 96 hours and PRN. 6. Don gloves. 7. Clean catheter hub with alcohol pad and friction and allow to dry. 8. Hold catheter below heart level; clamp tubing and remove old injection cap/extension tubing and discard. 9. Place a sterile syringe in the open port to protect catheter sterility, then clean around the threads of the catheter to remove any debris. 10. Remove syringe and attach new injection cap/extension tubing onto hub snugly, maintaining sterility of tubing/new inject cap and inner catheter lumen. 11. Scrub injection cap vigorously with alcohol pad and allow to dry. 12. Confirm patency and flush with normal saline and heparin per protocol using push-pause method. 13. Document injection cap change in medical record.
PICC dressing changes	**PICC dressing changes** 1. Obtain supplies (tegaderm, chloraprep, sterile cloves, face mask). 2. PICC dressing changes are performed every 7 days or if the dressing is wet, non-occlusive, or if there is significant drainage under the dressing. 3. Explain procedure to patient. 4. Position patient in bed with arm at side. 5. Perform hand hygiene. 6. Apply mask and don clean gloves for dressing removal. 7. Remove current dressing. 8. Inspect site for signs and symptoms of infection, catheter, catheter migration and integrity of catheter and sutures. 9. Remove gloves and perform hand hygiene. 10. Prepare supplies for dressing. 11. Don sterile gloves using sterile technique. 12. Cleanse site with Chloraprep using friction in a horizontal, vertical and circular motion for at least 30 seconds and allow to dry. 13. May apply skin protectant barrier around perimeter where dressing will be applied (not near the insertion site) to improve adherence of the dressing. Allow to dry. 14. Apply occlusive dressing over the insertion site. 15. Secure extension tubing if patient has one. 16. Label dressing with date, time, and initials. 17. Remove gloves and perform hand hygiene. 18. Document site and catheter assessment and dressing change in the medical record.
PICC removal	**PICC removal** 1. Check for providers order. 2. Patient assessment (reviews patient's labs for platelet count, prothrombin time, activated partial thromboplastin time and INR, as applicable). 3. Consider whether the patient is receiving anticoagulant therapy. 4. Observe catheter site for redness, warmth, tenderness, or presence of drainage. 5. Explain procedure to patient. 6. Obtain supplies: PPE(goggles, mask and gown as appropriate). a. Chloraprep b. Suture Removal kit c. Sterile Gauze dressings d. Tegaderm dressing 7. Perform hand hygiene. 8. Don gloves and PPE as appropriate.

9. If patient on IV infusions through PICC, turn off.
10. Place the patient in slight trendelenburg or supine position as tolerated.
11. Remove dressing and discards. Assess for any signs or symptoms of infection. If present, notify provider.
12. Perform hand hygiene.
13. Don gloves.
14. Prep site with chloraprep. Allow to dry.
15. Remove sutures with suture removal kit.
16. Instruct patient to take a deep breath and hold or bear down.
17. If contraindicated or patient non-compliant remove catheter during exhalation.
18. Retract catheter parallel to skin smoothly and steadily pulling out 1-2 inches at a time until completely removed.
19. Apply sterile gauze dressing with firm pressure over exit site until hemostasis is achieved. Recommendation of 30 seconds of pressure to the site.
20. Apply clean sterile gauze pad and cover with tegaderm.
21. If patient able, have them remain in supine position for 30 minutes after catheter removal.
22. Leave dressing in place for 24 hours,
23. Change dressing every 24 hours and prn until the site is healed,
24. Inspect catheter tip to ensure tip is intact,
25. Measure length of the catheter and confirm with length documented in progress notes if able to find information,
26. Document in medical record date, time and internal length of catheter. Monitor for signs and symptoms of infection,

Regulatory Reference Sources	
OBRA Regulatory Reference Numbers	
Survey Tag Numbers (optional)	