Central Venous Access Device
WEST COAST UNIVERSITY

Student:

		Peer 1	Peer 2	Faculty Evaluation
NPSG	Wash hands per CDC guidelines.			
	Provide patient privacy.			
NPSG	Introduce yourself.			
NPSG	Identify patient correctly using two identifiers (check to chart).			
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.			
Implanted Port				
	Accessing 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 noncoring 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.			
	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 in a 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.			
	Obtaining Blood Sample:			
	Assess site condition check for indication of infection.			
	Temporarily turn off any infusing solutions, if applicable. 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.			
	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 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.			
NPSG	Dispose of soiled supplies in biohazard bag and wash hands per CDC guidelines.			
	Discontinuing an Infusion:			

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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.				
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.			

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Implanted Port Continued				
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 return. 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 and tape with sterile gauze if bleeding.				
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.			
Peripherally Inserted Central Catheter (PICC)				
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.				
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.			
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.				
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.				
Assess site and examine catheter and hub. Measure external portion of catheter. Compare to previous length to detect migration.				
Remove gloves, discard dressing and gloves.				
Perform hand hygiene.				
Open sterile dressing kit, prepare sterile field and don sterile gloves.				
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.				
Coil external portion of catheter and tape in place. Label dressing with date time and initials.				
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.			

PEER #1:

PEER #2:

Faculty Evaluator:

Comments: