HHF PROCEDURE

ORIGINAL DATE: 08/91
REVISION DATE: 09/14

SUBJECT: CENTRAL VENOUS CATHETERS

PURPOSE: To provide central venous access for administration of fluids, TPN, medications, blood products or to draw blood for laboratory analysis.

Considerations

1. LPNs working in New Hampshire may not care for central lines based on the NH State Practice Act.
2. Central venous catheters will be accepted for home care under the following circumstances.
   a) The line is sutured, tunneled in place or has a securement device.
   b) A copy of the post-insertion x-ray report, ultrasound report or Vasonova VPS report verifying proper placement of the line is available to the agency. Line length, type and size will be documented on the discharge paperwork from the facility where it was placed. If the length is not available, line may not be removed by VNA.
3. Central line dressings will be routinely changed 1-3 times a week as ordered by MD and/or depending on patient's diagnosis and condition and PRN if soiled or wet. Dressings will be done using aseptic technique and sterile occlusive dressing procedure.
4. If utilized for intermittent infusion of medication or solutions, central venous catheter will be capped with needleless luer lock type injection caps to be changed 1-3 times a week and PRN and irrigated with N/S before and after each med followed with an appropriate dose of heparin flush solution after each dose of medication. If meds are not being administered, flush according to manufacturer's recommendations and/or physician's orders.

   Recommended Flushes**
   a) Hickman Catheter: 5ml 10 units/ml heparin flush each lumen daily.
   b) Venous Access Device (Portacath): 5ml 100 units/ml heparin once a month.
   c) Subclavian/Jugular Catheter: 5ml 10units/ml heparin flush each lumen daily
   d) Valved Catheter: 10ml normal saline flush each lumen once a week.
   e) PICC Lines: 5ml l0 units/ml heparin daily.

   **** NOTE**: Pediatric patients, patients with coagulation disorders and dialysis patients must have specific physician orders for flushes.

5. All lines will be assessed for pain, erythema, edema or drainage at each visit. If PICC line, arm circumference will be measured 2" above site and amount of catheter outside site will be measured with weekly dressing changes.
6. Any signs of catheter related infection or other complications should be reported to the physician as soon as suspected, and documented in the vital sign screen of note.
7. Nurses will evaluate for and recommend removal of non-essential catheters.
8. Tunneled catheters will not be removed by a nurse.

a) Subclavian/Jugular and PICC catheters may be removed by RNs trained in removing these lines, with a physician's order. If resistance is met, stop immediately, have patient lie down, relax, deep breathe and attempt again in 10 minutes. If still unable, redress catheter and call physician to order Valium. Instruct patient to call agency when medication arrives to schedule a visit 45 minutes to one hour after Valium taken.
b) No non-tunneled catheter or PICC line will be removed without documented length from the facility where the line was placed.
c) After line removal, a sterile occlusive dressing with antibacterial ointment must be applied to the insertion site for 48 hours. Catheter is to be measured to assure complete catheter removal. Teach patient/caregiver to keep dressing dry and intact. No heavy lifting for 48 hours and apply pressure for 5 minutes if site begins to bleed.

References

1. Infusion Nurses Society, 2011 Infusion Nursing Standards of Practice
2. The Joint Commission National Patient Safety Goals

Approved Policy Committee: 12/11
Revised 09/14 Per Policy Committee Recommendation