POLICY

High Peaks Hospice (HPH) will properly maintain Peripherally Inserted Central Catheters (PICC) in order to provide an optimal symptom management delivery system. The Registered Nurse (RN) Case Manager will be responsible for maintaining a PICC.

PROCEDURE

1. ROUTINE CARE

   A. Dressing Changes:
      1) Include care of catheter in care plan
      2) Equipment needed – sterile central line dressing kit, clean gloves, occlusive dressing (tagaderm, coverderm)
      3) Procedure
         Step 1: Explain the procedure to patient
         Step 2: Wash hands
         Step 3: Prepare dressing kit on a clean, flat area
         Step 4: Put on clean gloves and remove old dressing from vascular access device
         Step 5: Using dressing kit, clean insertion site with antiseptic cleaner provided.
            After drying for 1 minute place new sterile occlusive dressing over insertions site.
         Step 6: Repeat every 7 days and as necessary if site becomes soiled or wet.

   2. Flushing:
      1) The catheter is flushed after each use or once per day with 3-5cc normal saline. Always flush catheter with a 10-cc syringe, a small syringe can create high pressure and cause the catheter to rupture.
      2) This can be taught to patient and caretaker for daily maintenance.

2. ASSESSMENT

   During each visit to patient the RN will assess and document the following concerning the PICC line:
A. Integrity of bio-occlusive dressing

B. Integrity of insertion site

C. Integrity of catheter track

D. Patient pain or discomfort

E. Complications for PICC therapy and report any complications to attending physician

F. Mid-arm circumference weekly

G. Caps change every 7 days

H. Dressing change every 7 days

3. POINTS TO REMEMBER

A. Do not use syringe smaller than 10ccs when working with a PICC line

B. Do not use alcohol or acetone directly on catheter

C. Protect the catheter from direct water spray when patient is showering by covering the dressing with plastic wrap

4. DOCUMENTATION

Document assessments and interventions in patient’s medical record; update care plan as appropriate.

5. REPORTABLE CONDITIONS

Notify attending physician and discontinue use of PICC line for:

A. Signs of air embolism: Chest pain, dyspnea, confusion, hypoxic symptoms, apnea, tachycardia, hypotension, nausea, substernal pain. Note: Place patient in a left side lying position with head down (Reverse Trendelenburg)

B. Signs of thrombophlebitis/deep vein thrombosis/infiltration: edema of the arm, neck, or chest, distended neck vasculature, development of visible collateral circulation in the chest, and/or an increase in the mid-arm circumference of greater than 2cm

C. Signs of catheter migration/malposition: decrease in external catheter length, complaints of ear, jaw, teeth and neck pain
D. Catheter embolus/rupture

E. Catheter Occlusion: causes include catheter tip resting against the vein wall, catheter kink, fibrin sheath, catheter clot, drug precipitate, venous thrombosis.
   1) Signs and symptoms include inability to flush fluids through catheter or obtain a blood return.
   2) Flush catheter with a 10cc syringe or larger only. A smaller syringe produces increased pressures and may cause the catheter to rupture.

F. Accidental removal
   1) Apply a pressure dressing to exit site.
   2) Assess hemostasis.

G. External catheter leakage or breakage. Signs and symptoms include unexplained dressing dampness or wetness and observed leaking during catheter irrigation.


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