Peripherally Inserted Central Catheter (PICC) Dressing Change & Cap Change

Name _____ Department _____

In order to be certified for this advanced competency, each step in the procedure must be demonstrated in the presence of a mentor 3 times. Please complete to the Halogen eLearning module, "Peripherally Inserted Central Cather (PICC) Dressing Change" prior to performing this skill on a patient.

You must self-assess whether you have the knowledge skills and judgment to perform the skill. It is your responsibility to seek out additional resources if required.

Procedure	Date Mentor's Initials	Date Mentor's Initials	Date Mentor's Initials
1. Gather and prepare the necessary equipment			
2. Perform hand hygiene.			
3. Confirm the patient's identity using at least two patient identifiers.			
4. Provide privacy.			
5. Explain the procedure to the patient and family (if appropriate) according to their individual communication and learning needs.			
6. Raise the bed to waist level before providing care and position the patient.			
7. Perform hand hygiene.			
8. Put on a mask.			
9. Perform hand hygiene.			
10. Assemble your supplies on a sterile field.			
11. Perform hand hygiene.			
12. Put on gloves.			
13. Position the patient with the arm extended away from the body and with the insertion site below heart level.			
14. Visually inspect the entire infusion system.			
15. Inspect the catheter-skin junction and surrounding area and palpate through the intact dressing for redness, tenderness, swelling, and drainage. Pay attention to the patient's reports of pain, paresthesias, numbness, or tingling.			
16. Visualize the markings on the catheter and note how far the PICC line is protruding from the insertion site.			
17. Remove the existing dressing by beginning at the device hub and gently pulling the dressing perpendicular to the skin toward the insertion site (i.e. start distally and remove the dressing towards the patient).			
18. Remove and discard the engineered stabilization device (Statlock): • Use a chlorhexidine or alcohol swab to dissolve the adhesive on the device for easy removal.			
19. Inspect the integrity of the catheter and hub.			

Procedure	Date	Date	Date
	Mentor's Initials	**Mentor's Initials**	**Mentor's Initials**
20. Remove and discard your gloves.			
21. Perform hand hygiene.			
22. Put on sterile gloves.			
23. Clean the skin with antiseptic swabs following the manufacturer's instructions: • For chlorhexidine (preferred), apply with an applicator using a vigorous side-to-side motion for 30 seconds, and then **allow the area to dry completely**. • For povidone-iodine solution, apply with a swab, beginning at the insertion site and moving forward in concentric circles. Allow the solution to dry completely (typically 1½ to 2 minutes).			
24. Apply skin barrier to surrounding skin. Allow to dry (paper dry, not tacky).			
25. Clip wings of PICC into the securement device then secure the securement device to the arm.			
26. Apply transparent dressing placing the insertion site in the middle of the window for clear visibility.			
27. Apply one piece of sterile tape under the protruding PICC catheter as close as possible to the transparent dressing.			
28. Apply one piece of sterile tape on top of the protruding PICC catheter over the first piece of tape. • Refer to Fast Facts – Peripherally Inserted Central Catheter (PICC) Dressing Change and the Halogen eLearning module, "Peripherally Inserted Central Cather (PICC) Dressing Change" for more information.			
CHANGING THE CAPS (with mask on):			
1. Place a sterile gauze or drape between the patient and the PICC ports.			
2. Prime sterile needless access cap with 0.5ml normal saline. Ensure the cap is functional.			
3. Remove existing needless access cap and perform a vigorous mechanical scrub of the hub for at least 15 seconds using a chlorhexidine swab. Allow it to dry.			
4. Apply the new, primed needless access cap.			
5. Flush with 10 ml Normal Saline using turbulent push-pause method.			
6. Create positive pressure by slowly removing the syringe while injecting the last 0.5 mls of saline.			
7. Discard used supplies in appropriate receptacles.			
8. Return the bed to the lowest position.			
9. Remove and discard your gloves and mask.			
10. Perform hand hygiene.			
11. Document the procedure.			
Name of Mentor, Discipline, Department	Initials	Initials	Initials