SAMPLE POLICY & PROCEDURE

Legal Issues: PICC Line and Midline Program

Outline:

1. State regulations regarding PICC Line or Midline placement
2. Nursing qualifications to place a PICC Line or Midline
3. Nursing competency
4. Policies and Procedures for PICC Lines and Midlines
5. Patient consent for PICC Line or Midline placement

State Regulations regarding PICC Line or Midline placement:

As of 1994, all fifty states either specifically include PICC Line placements within the scope of nurse’s practice, or make no statement either way. Every state currently has at least one or more nursing based PICC Line insertion programs. While it is legal for nurses to insert PICC Lines throughout the United State, each state does differ on restrictions and provisions it imposes on placements. For example: some states allow no PICC Line placement in the home and some states require x-ray verification of PICC Line tip position. It is important to know what your states policy is regarding PICC Line placement. The attached table (taken from the 1999 “Bard Access Systems PICC / Midline Training Manual” & the INS Course “Peripherally Inserted Central Catheter (PICC) Midclavicular and Midline Catheters” published in 1999) looks at the position of each State Nursing Board with regard to suturing, lidocaine usage, home placements etc. In addition, a table of State Board of Nursing addresses is available for those individuals wanting updated information. With technological changes nurses are investigating the use of modified Seldinger® technique. As you will see from the tables most states do not restrict the utilization of this technique for those states that do it is best to contact them directly for an opinion. When addressing a state it is important to identify other states where modified Seldinger® technique is utilized successfully by nursing and the improved patient outcomes that may result from using this technique. It is also important to confirm in writing that the modified Seldinger® technique does not utilize the physician approach of threading a catheter over a guide-wire. But rather it uses a short stylet (15 cm.) wire to ascertain vein patency ad then utilizes a dilator over the wire (60 cm) to actually thread the PICC Line. The technique for Seldinger® versus modified Seldinger® vary greatly.

Note: There is no State Board of nursing restrictions on the issue of Registered Nursing placement of Midline catheters.
Nursing qualifications to place a PICC Line or Midline:

INS (Intravenous Nursing Society (617) 441-3008) is the only organization to reference qualifications for a nurse placing a PICC Line or Midline catheter. This information has been referenced from the Intravenous Nurses Society Position Paper entitled “Peripherally Inserted Central Catheters (PICCs) and the Intravenous Nursing Society Course entitled “Peripherally Inserted Central Catheter (PICC) Midclavicular and Midline Catheters Assessment and Planning, Care and Maintenance, Complications”

Recommended criteria & components of an institution's PICC Line and Midline program
1. Choose a clinician that is a licensed physician or licensed registered nurse as determined by state regulations
2. Choose a clinician that is educated with demonstrated competency and proficiency in intravenous therapy
   - Including the insertion of short peripheral catheters
   - Solid understanding of central venous catheters
3. Provide the registered nurse with an educational program for PICC insertion
   - The educational program must include theoretical content and clinical instruction on an anatomical model
4. Ascertain that the nurse has validated initial competency. There must be an ongoing continuum of competency
   - Establish a program for maintaining clinical competency for device insertion
     - Which includes the knowledge and ability to perform the insertion safely
     - Which includes knowledge of care and maintenance strategies
5. Program and clinician qualifications must be consistent with state and federal laws
6. Documentation of insertions and outcomes analysis must be performed. Each organization must set up its own requirements for initial qualifications and re-qualification.

Recommended Education for Clinicians inserting PICC Lines and Midline Catheters
1. Documented 1600 hours of clinical practice with I.V. therapy responsibilities during the previous two years
2. Documented experience in central venous device management
3. Completion of a course in PICC and extended duration peripherally inserted catheter instruction:
   - The cognitive portion of this program must be completed through
     (a) Classroom attendance
     (b) Self-study modules
     (c) Interactive training techniques
     (d) Combination of 1, 2, and 3
Recommended education for the clinician caring for PICC Line and Midline catheters:

1. The nurse should be knowledgeable in the following areas:
   - All routine nursing care tasks including: dressing change, tubing/injection cap change, flushing, and blood withdrawal procedures
   - All possible complications associated with the chosen device and the recommended methods to manage those complications
   - Performance improvement and documentation of outcomes
   - The design, indications, contraindications, precautions, for the specific device being used as written in the manufacturer’s literature
   - The methods of infusion through the device including:
     - Possible flow rates
     - Pressure ratings of catheter
     - Infusion pressure from the chosen flow control device
     - Considerations for manual injections with syringes
   - Additional resource people to contact for assistance
     - Nurse who inserted the device
     - Clinical support from manufacturer

Recommended qualifications for clinicians teaching PICC Line or Midline Catheter insertion:

1. Must meet all of the recommendations for clinicians inserting these devices
2. Documented (5) successful catheter insertions in order to mentor or observe the insertions of another clinical – **Precepting Criteria**
3. And (25) insertions in order to teach PICC Line or Midline catheter insertion – **Teaching Criteria**
4. The instructor should have documented understanding of the principles of adult learning and employ these principles in:
   - Assessing the learner’s needs
   - Program development processes
   - Appropriate teaching and learning strategies
   - Evaluation processes
Nursing competency:

INS (Intravenous Nursing Society) recommends that an institution create a set criteria to evaluate the competency of nurses learning to place PICC Line / Midline catheters. This process should be ongoing such as a yearly competency of nurses placing PICC Line or Midline catheters.

However, it should be noted that nurses can not be certified in PICC Line or Midline catheter placement or care and maintenance. The formal definition for certification involves taking a test from an organization or state with a certification board. However, nurses may be qualified (deemed competent) for PICC Line or Midline Catheter placement or care and maintenance, in your particular institution. It has been suggested by some State Boards of Nursing that nurses observe (1) – (3) successful insertions and performs under supervision (3) – (5) successful insertions. Some State Boards of Nursing require that the employer keep this documentation on file.

For your convenience a template has been developed for clinician competency in the form of a checklist. Please fill free to utilize this template in creating your own institution competency evaluation form.

Qualification Requirements for PICC Line & Midline Catheter Insertion

Qualifying training, experience and evaluation:

- Successfully complete theoretical course with Didactic (with supervised practicum)
- Successful insertion PICC Line and / or Midline catheter on Peter PICC® or practice arm
- Observe ______ successful insertions by a qualified clinician placing PICC Lines or Midline catheters
- Be observed placing ______ successful insertions by a qualified preceptor placing PICC Lines and / or Midline catheters (see qualification skills checklist)

Annual re-qualifying experience and evaluation:

- Minimum insertion of _____ catheters per year must be completed to maintain competency. The employee performed ______ PICC Line insertion ________year and _________Midline insertions _________ year
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- Annual evaluation by qualified preceptor placing PICC Lines and/or Midline catheters. The clinician is observed successfully placing _______ PICC Lines and or Midline catheters a year in accordance with the qualification skill competency checklist.

- Review of quality management data of PICC Line and Midline catheters placed during the past year

- Review of current manufacturer information, literature, guidelines, standards on PICC Line and Midline catheter insertion, care and maintenance, complication management and outcomes

*Copy of recorded training competency to be kept in employees personnel file*

Qualification Skills Checklist for PICC Line and/or Midline Insertion

<table>
<thead>
<tr>
<th>Activity Performed</th>
<th>Date Activity</th>
<th>Preceptor Name</th>
<th>Preceptor Title</th>
<th>Patient MR #</th>
<th>Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation</td>
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<td>Precept</td>
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<tr>
<td>Annual Competency</td>
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Clinician Name/Title: _______________ Employee Identification No. __________
## Competency Skills Checklist:

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<thead>
<tr>
<th>Competency Skill</th>
<th>Satisfactory</th>
<th>Not Satisfactory</th>
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<tr>
<td>PICC Line / Midline Catheter Placement</td>
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Prior to PICC Line or Midline Catheter insertion the competent clinician will:

- Review patient chart for:
  - Physician order (for Midline catheter insertion the physician order is for fluids or a standard peripheral catheter)
  - Patient allergies
  - Patient coagulation status
  - Patient contradictions to vascular access placement
  - Patient labs and medical history

- Explain:
  - Procedure to patient
  - Catheter management to patient
  - Obtain signed consent form (PICC Line only)

- Identify, Evaluate and Select:
  - Appropriate vein
  - Appropriate insertion site
  - Location of artery
  - Choose appropriate catheter length and gauge size
  - Position patient properly
  - Correctly measures patient properly for catheter tip location
  - (optional) measures arm width

- Set-Up
  - Gathers appropriate equipment
  - Wash Hands
  - Set up equipment and sterile field with sterile technique / Utilize universal precautions / Utilize full barrier precautions
  - Preflushed catheter / syringes / extension sets etc. (trimming optional)

During PICC Line and Midline Insertion:

A. Perform appropriate
  - Skin Prep (place tourniquet / change gloves)
  - Sterile draping of insertion arm and site
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### During PICC Line and Midline Insertion:
- Perform Appropriate:
  - Venipuncture / observe flashback
  - Modified Seldinger® (optional)
    - Use of wire
    - Use of Scalpel
    - Use of dilator
  - Advance Catheter (check patient positioning of head)
  - Remove introducer (dilator)
  - Remove guidewire
  - Attach hub (Groshong®)
  - Ascertain blood return
  - Suture or utilize securing method
  - Apply dressing

### Upon Completion of insertion:
- Document in patient medical record:
  - Allergies
  - Site limitations
  - Blood coagulation problems
  - Patient complications that occurred during insertion
  - Contraindications to usage of line placed
  - Patient teaching / Patient consent
  - Anesthetic used
  - Catheter gauge size (french), number of lumens, length, suspected tip position (awaiting x-ray), vein and insertion site
  - Describe general sterile insertion and problems encountered
  - Arm circumference (optional)
  - Catheter lot number and brand
  - Catheter method of securement and dressing
  - Blood return and flushing
  - Contact Radiology for chest x-ray

Provide the patient
- Patient care handbook and care instruction

Provide the nursing staff
- Patient status report
- Instructions: flush protocol, hot packs, dressing changes

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**Upon Completion of insertion:**

- **Contact Radiology**
  - Confirm catheter tip position and re-position / re-dress if needed or send to Interventional Radiology for re-positioning if available
  - Ascertain nursing staff has been contacted and physician regarding catheter tip position and usage
  - Document approval from Radiology or Attending Physician to use catheter for infusion

**For Discontinuation of catheter:**

- A. Review order for catheter removal
- B. Assess need for catheter tip culture and or blood cultures (perform if needed)
- C. Removal process
  - Wash hands / Utilize universal precautions
  - Assess patient and site
  - Speed of removal (slow) Observe how clinician handles complications
    - If unable to remove apply heat and wait
    - If unable to remove contact physician for possible x-ray or venogram need
  - Confirm catheter measurement
- D. Documentation post removal
  - Patient complications during removal
  - Measurement of catheter length compared to insertion length
  - Patient tolerance
  - Cultures or labs sent for analysis
- E. Report to Staff Nurse
  - Any complications during removal of catheter / How to handle complications
  - Patient tolerance

Attach list of articles / manufacturer literature / continuing education related to re-qualification of competency for PICC Line and / or Midline catheter insertion.
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Summary:

If we review State Board of Nursing recommendations and INS (Intravenous Nursing Society Standards & Position Statement) the following conclusions regarding PICC Line qualifications for a Registered Nurse can be drawn. Midlines have few recommendations from State Board of Nursing Agencies except to say that they do not have to be x-rayed. There is no documentation that Midlines need a separate physician order besides the originally written physician order. PICC Lines however, have consistent recommendations as follows from state to state:

1. The RN who wishes to place and remove PICC Lines should attend an educational course that lasts approximately 6 – 8 hours in duration
2. This course must include: anatomy, physiology, care and maintenance, pharmacology, patient education, patient selection, emergency and non-emergency complication management, sterile insertion technique, quality assurance management and data collection
3. This course must have a theoretical component and a hands on practicum with supervision
4. The employer must have policies and procedures available on insertion and complication management
5. The RN who places PICC Lines must prove that they have attended a course and the employer should have proof of attendance on file
6. The RN who places PICC Lines needs to prove competency in the technique of PICC Lines placement. Some states have defined this competency as (1 – 3) observed insertions and (3-5) successful insertions observed by a proficient RN. This documentation should be on file with the employer.
7. The RN who places PICC Lines needs to prove competency yearly
8. The RN who is learning to place PICC Lines should be precepted by a competent, qualified, and knowledgeable RN
9. Radiographic confirmation of catheter tip position is optimal
10. The LVN or LPN role in PICC Line placement is limited
11. PICC Lines should have a written physician order
12. Continuing education is a requirement for nurses placing PICC Lines
Patient Consent

(Information taken from “Nurses and The Law A Guide to Principles and Applications” by Nancy J. Brent published in 1997 by W.B. Saunders)

Informed Consent:

A patient’s right of informed consent includes knowing and understanding what health care treatment is being undertaken. Obtaining informed consent is also important to the health care provider for without it; he or she may be subject to lawsuit alleging assault, battery, negligence, or a combination of these causes action.

Types of Consents:

1. Expressed Consent:
   - Oral declaration concerning a particular treatment (“Yes”)
   - Written document (a consent form) that the patient signs. The written consent is used often for PICC Line placement.
   - A written consent is not required but provides evidence to prove that consent was obtained if a suit is filed alleging that consent was not obtained prior to treatment.

2. Implied Consent:
   - Is consent that is giving by an individuals conduct rather than a verbal or written consent. Such as a patient sticking their arm out for a blood pressure implies consent

Elements of Consent:

1. Patient must have decision-making capability (A parent, guardian, or family member may have to provide consent)
2. Consent must be in patient’s native language at their educational level
3. Consent must be given voluntarily and freely without duress or coercion
4. Consent must not be obtained under fraudulent circumstances
5. The patient must have knowledge and understanding of the proposed medical regimen. (Ask the patient if they have any questions regarding their procedure and provide written instruction regarding their procedure)
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Who Should Obtain the Consent?

1. Physician who is doing the procedure
2. Clinician (Nurse) who is doing the procedure
3. Key: Who is performing the procedure and documenting the consent in the patient medical records and could testify as to what was said to the patient

Information to be Provided During Consent:

1. Patient diagnosis
2. Type of treatment or procedure or medication
3. Explanation of procedure or treatment or medication and its intended purpose
4. Hoped for benefits from the proposed treatment, procedure or medication (with no guarantees to outcomes!)
5. Material risks, if any of the treatment, procedure or medication
6. Alternative treatments, if any
7. Prognosis if the recommended care, procedure, treatment, or medication are refused

Documentation of Informed Consent:

1. Blanket consent forms are the type of consents signed on patient admittance which is not treatment specific. It arguably gives a health care provider unbridled authority and discretion to provide whatever treatment is decided upon by the provider. These are not recommended for treatment specific procedures. It is up to your institution to determine if PICC Line and Midline insertion require a treatment specific consent.
2. Battery Consents protect health care providers against allegations of battery and include information specific to a particular procedure or treatment. They are different from treatment specific consent forms, which are detailed.
3. Treatment Specific Consents are written and are very detailed in description of the procedure, complications and alternatives. These are often used for the placement of central lines (PICC Lines).

The use of a written consent form to document permission for treatment cannot avoid all legal problems. The patient can challenge the way in which the consent was obtained, what information was shared concerning the recommended treatment, or other aspects of the process of obtaining informed consent. Challenges can also be raised about the form itself. It is best to contact Risk Management in your hospital to evaluate the need for a written consent for PICC Line and / or Midline catheter placement. No matter how the consent is obtained verbally or written documentation in the patient’s medical record is crucial. For your information a sample consent is attached.

DRAFT
10/16/06
I agree to have a Peripherally Inserted Central Catheter (PICC) placed in my arm.

The catheter insertion procedure, care, maintenance and, complications have been explained to me and I understand them.

I understand that this is not the only way I can receive my medication. I understand that my health care team has determined that the PICC line would be the safest and most effective means of giving my medication at this time.

Alternative vascular access device options __________________________________________ of giving my medication have been explained to me and I have chosen this one.

I realize this procedure will be performed only by a nurse who has been specially trained and certified to insert PICC lines.

My catheter will be inserted by ____________________________.

I realize that this is an invasive procedure and has certain risks such as catheter or air embolism, arterial puncture, infection, irregular heartbeat and venous thrombosis.

I understand that while the catheter will be placed in my upper arm the end of the catheter will come to rest in an area near my heart.

I have the right to voice any questions I may have about this procedure and I expect knowledgeable answers. I also understand that (Institution Name) has specific policies relating to the care which will be given to me and include provisions for termination of services at my request, the request of physician, and/or at the decision of the agency.

I agree to abide by the terms of these policies in all respects.

__________________________   _________________________
Patient Signature       Date

__________________________   __________________________
Witness        Date

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Policy and Procedure
PICC Line (Peripherally Inserted Central Catheter)

Policy:

Product Description and Indications:

- The Per-Q-Cath® PICC Line and the Groshong® PICC Line is indicated for short or long term peripheral access to the central venous system for intravenous therapy and blood sampling.
- The Per-Q-Cath® Midline and Groshong® Midline catheters are indicated for short term or long term peripheral access to the peripheral system for selected intravenous therapies and blood sampling (see contraindications)
- For blood therapy it is recommended that a 4 French or larger catheter be used.
- PICC Line and Midline catheters are made from specially formulated and processed medical grade materials for reliable long (greater than 30 days) and short (less than 30 days) vascular access.
- PICC Line catheters are an effective vascular access device in adults, children and infants.
- Patient’s who may benefit from a PICC Line are mid to long term IV therapy. These patients include (but are not limited to): chronic disease, have limited venous access, receive vesicant / irritant drugs, need antibiotic therapy, etc.
- PICC lines have been an accepted technology since 1975, with extensive published research.

Contraindications:

- The device is contraindicated whenever:
  - The presence of device related infection, device related bacteremia, or device related septicemia is known or suspected.
  - The patient’s body size is insufficient to accommodate the size of the inserted device.
  - The patient is known or suspected to be allergic to materials contained in the device.
  - Past irradiation of prospective insertion site.
  - Previous episodes of venous thrombosis or vascular surgical procedures at the prospective placement site.
  - Local tissue factors that will prevent proper device stabilization and/or access.
- Midline catheter placement is contraindicated for patients requiring any of the following:
  - Solutions with final glucose concentrations above 10 percent.
  - Solutions with protein concentrations above 5 percent.
  - Continuous infusion of vesicants.
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Warnings:

- Polyurethane Per-Q-Cath® (only)
  - Use of ointments can cause failure of the device
  - Use of alcohol or acetone based solutions should not be used to clean the polyurethane Per-Q-Cath® catheter or skin site as the catheter may be adversely affected. Providone Iodine is the recommended antiseptic solution to be used
- Intended for single patient use. Do not reuse. Any device that has been contaminated by blood should not be reused or resterilized
- Providone-iodine is the suggested antiseptic to use. Acetone and tincture of iodine should not be used. 10% acetone / 70% isopropyl alcohol swabsticks used for dressing changes may be used for silicone Per-Q-Cath® and Groshong® PICC and Midline catheters
- After use thus product may be a biohazard. Handle and discard with universal and blood / body fluid precautions in mind (state, federal, local laws and regulations and accepted medical practice)

Qualification for Insertion:

- A licensed physician or a registered nurse who has demonstrated competency and have been educated in advanced intravenous therapy may insert a PICC Line or Midline catheter
- PICC Line and Midline catheters are commonly inserted into (but not limited to) the basilic, cephalic, median cubital veins of the antecubital area and upper arm. Care and maintenance shall be performed by persons knowledgeable of the risks involved and qualified in the procedures
- The tip of the PICC Line resides in the superior vena cava. The tip of the midline lies in the peripheral vein system below the axillary vein
- A physician’s order is needed for PICC insertion.
- Tip verification is required by radiographic confirmation prior to initiation of infusion therapy (PICC Line only)
- For Bard Access Systems products: Per-Q-Cath PICC / Midline or Groshong PICC / Midline information, literature or video (insertion & maintenance techniques) may be obtained by contacting (800)-443-3385

Precautions:

- Follow universal precautions when inserting and maintaining catheters
- Follow all contraindications, warnings, cautions, precautions, and instructions for all infusates specified by the manufacturer
- Use aseptic technique whenever the catheter lumen is opened or connected to other devices
- The fluid level in the catheter will drop if the connector is held above the level of the patient’s heart and opened to air. To prevent a drop in the fluid level (and thus air
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entry) while changing injection caps, hold the connector below the level of the patient’s heart before removing the injection cap.

Procedure:

1. Prior to beginning the placement procedure, do the following:
   - Examine the package carefully before opening to confirm its integrity and that the expiration date has not been passed. Do not use package if it is damaged, opened or the expiration date has passed. Inspect kit for inclusion of all components
   - Flush the catheter with sterile normal saline or heparinized saline prior to use.

2. To avert device damage and /or patient injury during placement:
   - Avoid accidental device contact with sharp instruments and mechanical damage to the catheter material. Use only smooth edged atraumatic clamps or forceps
   - Avoid perforating, tearing, or fracturing the catheter when using a stylet
   - Do not use catheter if there is any evidence of mechanical damage or leaking
   - Avoid sharp or acute angles during implantation which could compromise the patency of the catheter lumen(s)
   - Do no place suture around the catheter as sutures may damage the catheter or compromise catheter patency. Groshong catheters (only) the provided suture wings will secure the catheter without compromising catheter patency
   - Do not cut sylet

3. After placement, observe the following precautions to avoid device damage and / or patient injury
   - Do not use the device if there is any evidence of mechanical damage, or leaking. Damage to the catheter may lead to rupture, fragmentation and possible embolism and surgical removal. If the Groshong® catheter is damaged, it should be clamped with an atraumatic clamp, or kinked closed if a clamp is unavailable, until the catheter can be replaced or repaired.
   - Use only leur lock connections for accessories and components used in conjunction with this device
   - If signs of extravasation exist discontinue injections. Begin appropriate medical intervention immediately
   - Infusion pressure greater than 25 psi (172 kPa) may damage blood vessels and viscus and is not recommended
   - Do not use a syringe smaller than a 10 cc (smaller syringes generate more pressure than larger syringes). A two-pound weight of equivalent force on the barrel of a 3-cc syringe generates in excess of 45 PSI. The same two-pound weight on the barrel of a 10-cc syringe generates less than 7 PSI of pressure.
   - Do not infuse against resistance. Follow standard institution policy / procedure to clear a blocked catheter
   - Published data indicates that a PICC Line may be damaged by the use of high pressure injectors in Radiology
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- Caution should be used when taking blood pressures on the arm of a patient with a PICC Line or Midline catheter in place as that could damage the catheter
- Caution should also be used by taking peripheral phlebotomies at or above the insertion site of a PICC Line or Midline as that could damage the catheter

Possible Complications:

<table>
<thead>
<tr>
<th>Cause</th>
<th>Possible Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air Embolism</td>
<td>Bleeding, Brachial Plexus Injury, Cardiac Arrhythmia, Cardiac Tamponade</td>
</tr>
<tr>
<td>Catheter Erosion Through the Skin</td>
<td>Catheter Embolism, Catheter Occlusion, Catheter Related Sepsis, Endocarditis</td>
</tr>
<tr>
<td>Exit Site Infection</td>
<td>Exit Site Necrosis, Extravasation, Fibrin Sheath Formation, Hematoma</td>
</tr>
<tr>
<td>Intolerance Reaction to Implantable Device</td>
<td>Laceration of Vessels or Viscus, Perforation of Vessels or Viscus, Phlebitis, Spontaneous Catheter Malposition or Retraction</td>
</tr>
<tr>
<td>Thromboembolism</td>
<td>Vessel Thrombosis, Vessel Erosion, Risks Normally Associated with Local or General Anesthesia, Surgery and Post Operative Recovery</td>
</tr>
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Insertion Instructions:

1. Evaluate chart for physician order (PICC Line requires a central line order) (Midline require a peripheral order or peripheral infusate order)

2. Review patient’s medical history, contraindications to device placement, indications to device placement, allergies, coagulation status and labs

3. Verify patient’s identity. Explain procedure to patient and family

4. Prepare a clean work area and gather the supplies

5. Wash hands with an antimicrobial soap prior to beginning the insertion procedure. In accordance with *Intravenous Nursing Policies and Procedures for Infusion Nursing 2000* “wash intended cannulation site with anti-infective soap and water if necessary” “remove excess hair from intended cannulation site with clippers or scissors (optional)” page 76-77

6. Select the appropriate vein by placing a tourniquet firmly around the upper arm. Examine the antecubital fossa and upper arm preferably basilic, cephalic or median cubital basilic veins are used) and select a vein (may use Site Rite® ultrasound).
After selecting the vein, locate the brachial artery to avoid inadvertent puncture (may use Site Rite® ultrasound). Release the tourniquet, leaving it in place under the arm.

7. Position the patient supine with the arm to be accessed away from the trunk of the body at a 90-degree angle. (PICC Line and Midline) Have patient practice turning his/her head toward the arm of insertion and dropping his chin to the shoulder (PICC Line Only)

8. For (PICC Line only) and SVC placement measure from the planned insertion site to the right clavicle head, then down to the third intercostal space. For (Midline only) and peripheral placement, measure to desired tip location in the proximal portion of extremity, just distal to the shoulder and deltoid muscle. Note that the external measurement can never exactly duplicate the internal venous anatomy. Document measurement. Optional: measure mid arm circumference and document.

9. Taken from page 59 Intravenous Nursing Society Policies and Procedures for Infusion Nursing “Local anesthesia may include: transdermal analgesic cream “Use of transdermal (topical analgesic cream) apply layer of transdermal analgesic cream to cannulation site. Cover analgesic cream with transparent semipermeable membrane (TSM) dressing material for 60 minutes before venipuncture). Remove dressing material and disinfect site”

10. Optional: place a poly-lined drape under the arm to be cannulated.

11. Wash hands again with antimicrobial soap; gown, mask, and put on first pair of sterile gloves. Powdered gloves come in the Bard Access Systems full procedure tray. Should you have powdered gloves they should be washed before use with sterile saline. Powder on gloves can be removed by wiping gloves thoroughly with a sterile wet sponge, sterile wet towel, or other effective methods. Note the patient and inserter should put on masks per protocol.

12. Establish a sterile field for all supplies and place all supplies in the sterile field

13. Remove catheter from the tray and examine it along the entire length to ensure the stylet is straight. Any bending or kinks may make stylet removal difficult once the catheter is inserted into the vein.

14. Draw up 10 ml of 0.9% normal saline or normal heparinized saline and irrigate the catheter directly through the priming hub. Treat each lumen catheter as of a dual lumen catheter as though it were a separate catheter. Leave syringe attached during procedure.

15. Modification of catheter length (Per-Q-Cath product only) To modify the length of the catheter due to patient size, measure the distance from the insertion site to the desired tip location. Catheter depth markings are in centimeters. Retract the stylet to well behind the point the catheter is to be cut. Using a sharp scalpel or sterile
SAMPLE POLICY & PROCEDURE

scissors, carefully cut the catheter according to institutional policy. Caution: do not cut stylet. Inspect cut surface to assure there is no loose material.

16. Using aseptic technique prep the insertion site. *Intravenous Nursing Society Policy and Procedures for Infusion Nursing 2000* page 61-63 states “cleanse site using antiseptic solution (10% Providone-iodine / 2 to 3% aqueous chlorhexidine or 70% isopropyl alcohol ((use if patient is allergic to iodine))). Using friction, apply antiseptic solution in a circular motion. Begin at the center of intended insertion site and work to exterior edge. Allow antiseptic solution to air dry (i.e. do no blow or blot dry). If using chlorhexidiene, apply using sterile water, work into lather; rinse thoroughly with sterile water. If using Providone-iodine as the initial antiseptic solution, do not apply isopropyl alcohol as the second antiseptic solution because alcohol will negate iodine’s effect. If using isopropyl alcohol, apply for a minimum of 30 seconds.” Reminder for Bard Access Systems Per-Q-Cath polyurethane products it is not recommended to use alcohol or acetone based solutions rather use Providone-iodine solutions.

17. Discard used supplies, remove prep gloves, wash hands, re-apply tourniquet above the intended insertion site to distend the vessel and put on new pair of sterile non powdered gloves. Powdered gloves should be rinsed before use. (Powder on gloves can be removed by wiping gloves thoroughly with a sterile wet sponge, a sterile wet towel or other effective method).

18. Position sterile drapes around the insertion site (fenestrated drape over the anticipated puncture site) and over the tourniquet. You will need to be able to release the tourniquet through the drape without compromising the sterile field.

19. Palpate and locate the distended vessel.

20. Anesthetize the venipuncture site (optional). Taken from page 59 *Intravenous Nursing Society Policies and Procedures for Infusion Nursing* “Local anesthesia may include: transdermal analgesic cream, iontophoresis of lidocaine hydrochloride 2% with epinephrine 1:100,000 topical solution, intradermal injection of lidocaine hydrochloride 1% solution, intradermal injection of bacteriostatic 0.9% sodium chloride with benzyl alcohol preservative” “Use of iontophoresis follow manufacturer’s guidelines for anesthesia application” “Use of injectable (intradermal anesthetic – follow manufacturer’s guidelines for intradermal anesthesia injections. Disinfect site and allow to dry. Draw 0.3 cc of injectable anesthetic in tuberculin syringe. With needle bevel up, gently insert needle intradermally above intended cannulation site. Aspirate to confirm no blood return. Inject 0.1 cc to 0.3 cc anesthetic to form wheal at cannulation site. Remove needle and discard syringe in appropriate puncture resistant container. Monitor patient response.” For those utilizing the modified Seldinger® technique injectable anesthetic should be highly considered”
21. If using Site Rite® ultrasound prepare roll up the sterile sleeve, add sterile gel into the sleeve, pull the sterile sleeve over the non-sterile probe, add needle guide (if applicable) to the sterile bagged probe, put sterile gel onto the outside of the sleeve at the probe surface, locate chosen vein and identify artery to avoid

22. Perform Venipuncture using vein access technique per institutional policy

<table>
<thead>
<tr>
<th>Technique for Groshong® single lumen PICC Lines and Midline catheters – Safety Excalibur® Introducer</th>
<th>Technique for Groshong® dual lumen PICC Line and Midline catheters &amp; All Per-Q-Cath® products Safety Excalibur® Introducer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remove introducer needle cover</td>
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</tr>
<tr>
<td>Stabilize vein below intended access site with non dominant hand (unless using Site Rite® which is in non dominant hand)</td>
<td>Stabilize vein below intended access site with non dominant hand (unless using Site Rite®)</td>
</tr>
<tr>
<td>Grip only the introducer flashback chamber during the insertion</td>
<td>Grip only the introducer flashback chamber during insertion. Do not apply excessive pressure to the T-handles (peel apart sheath)</td>
</tr>
<tr>
<td>Perform venipuncture using shallow technique 15 – 30 degree angle. For Site Rite® place introducer into needle guide and perform venipuncture. Use needle guide angle to guide needle puncture.</td>
<td>Perform venipuncture using shallow technique 15 – 30 degree angle. For Site Rite® place peel away sheath (if available) into needle guide and perform venipuncture. Use needle guide angle to guide needle puncture.</td>
</tr>
<tr>
<td>After confirmation of blood return, lower introducer angle and advance approximately ¼ to ½ inches further to ensure positive cannulation of the vein. For Site Rite® after confirmation of blood return pull needle from introducer.</td>
<td>After confirmation of blood return, lower peel apart sheath angle and advance approximately ¼ to ½ inches further to ensure positive cannulation of the vein. For Site Rite® after confirmation of blood return pull needle from peel apart sheath.</td>
</tr>
<tr>
<td>Holding the needle stationary, advance the introducer into the vessel by pushing forward. Stabilize introducer, release tourniquet</td>
<td>Holding the needle stationary, advance the peel apart sheath into the vessel by pushing forward. Stabilize introducer, release tourniquet</td>
</tr>
<tr>
<td>Support the introducer to avoid displacement. Apply slight pressure to the vessel above the insertion site to minimize blood flow. Release the tourniquet. Withdraw the needle from the introducer.</td>
<td>Support the peel apart sheath to avoid displacement. Apply slight pressure to the vessel above the insertion site to minimize blood flow. Release the tourniquet. Withdraw the needle from the peel apart sheath.</td>
</tr>
</tbody>
</table>
**SAMPLE POLICY & PROCEDURE**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Apply pressure with nondominant hand over cannulated vein at tip of cannula to control bleeding and minimize blood exposure</td>
</tr>
<tr>
<td>2.</td>
<td>Insert the catheter through introducer (may use smooth non-grooved pick-ups to advance the catheter). Advance the catheter slowly. For central placement (PICC only) when the tip has advanced to the shoulder, have the patient turn head (chin on shoulder) towards the insertion side to prevent possible cannulation into the jugular vein.</td>
</tr>
<tr>
<td>3.</td>
<td>Continue advancing catheter to measured point for PICC Line or Midline tip position. Catheter depth markings are in centimeters. (Arm at 90 degree angle) If difficulty is encountered, moving arm to shoulder height may ease passage. Warning: for PICC Line avoid positioning the catheter tip in the right atrium.</td>
</tr>
<tr>
<td>4.</td>
<td>Stabilize the catheter position by applying pressure to the vein distal to the introducer. Withdraw the introducer from the vein. Slide the introducer catheter to the end of the PICC Line or Midline. Remove the suture wing from the delivery card. Squeeze the suture wing together so that it splits open. Place the wing around the catheter near the venipuncture site. Caution Note: To minimize the risk of embolization the suture wing must be secured in place.</td>
</tr>
<tr>
<td>5.</td>
<td>Stabilize the catheter position by applying light pressure to the vein distal to the insertion site. Slowly remove the stylet. Caution: Never use force to remove the stylet. Resistance can damage the catheter. If resistance or bunching of the catheter is observed, stop stylet withdrawal and allow the catheter to return to normal shape.</td>
</tr>
<tr>
<td>6.</td>
<td>Apply pressure with nondominant hand over cannulated vein at tip of cannula to control bleeding and minimize blood exposure</td>
</tr>
<tr>
<td>7.</td>
<td>Insert the catheter through peel apart sheath (may use smooth non-grooved pick-ups to advance the catheter). Advance the catheter slowly. For central placement (PICC only) when the tip has advanced to the shoulder, have the patient turn head (chin on shoulder) towards the insertion side to prevent possible cannulation into the jugular vein. For peel apart sheath you may remove the sheath after the catheter tip has been advanced 10 cm</td>
</tr>
<tr>
<td>8.</td>
<td>Continue advancing catheter to measured point for PICC Line or Midline tip position. Catheter depth markings are in centimeters. (Arm at 90 degree angle) If difficulty is encountered, moving arm to shoulder height may ease passage. Warning: for PICC Line avoid positioning the catheter tip in the right atrium.</td>
</tr>
<tr>
<td>9.</td>
<td>Stabilize the catheter position by applying pressure to the vein distal to the split apart sheath. Withdraw the split apart sheath from the vein and away from the site. Split the sheath and peel it away from the catheter.</td>
</tr>
<tr>
<td>10.</td>
<td>For Groshong® only: Remove the suture wing from the delivery card. Squeeze the suture wing together so that it splits open. Place the wing around the catheter near the venipuncture site. If the “Y” adapter of the dual lumen catheter is at the insertion site, the suture wing will not be needed. Caution Note: To minimize the risk of embolization the suture wing must be secured in place.</td>
</tr>
<tr>
<td>11.</td>
<td>Per-Q-Cath® only – Disconnect the T-Lock from the catheter leur connector. Stabilize the catheter position by applying light pressure to the vein distal to the insertion site. Slowly remove the T-Lock and stylet.</td>
</tr>
<tr>
<td>12.</td>
<td>Groshong® dual lumen – Stabilize the catheter position by applying light pressure to the vein distal to the insertion site.</td>
</tr>
</tbody>
</table>

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Withdraw both the catheter and stylet together approximately 2 cm and reattempt stylet removal. Repeat this procedure until the stylet is easily removed.

<table>
<thead>
<tr>
<th>Slowly remove the stylet.</th>
</tr>
</thead>
<tbody>
<tr>
<td>All catheters - Caution: Never use force to remove the stylet. Resistance can damage the catheter. If resistance or bunching of the catheter is observed, stop stylet withdrawal and allow the catheter to return to normal shape. Withdraw both the catheter and stylet together approximately 2 cm and reattempt stylet removal. Repeat this procedure until the stylet is easily removed.</td>
</tr>
</tbody>
</table>

- Modification of catheter length for single lumen Groshong Catheters – Using a sharp scalpel or sterile scissors carefully cut the catheter leaving at least 4 cm – 7 cm of the catheter for connector attachment. Insect the cut surface to assure there is no loose material.

- Attach connector to single lumen catheter – Retrieve the oversleeve portion of the connector and advance it over the end of the catheter. If you feel some resistance while advancing, gently twist back and forth or spin to ease its passage over the catheter. Gently advance the catheter onto the connector blunt until it butts up against the colored plastic body. The catheter should lie flat on the blunt without any kinks. With a straight motion slide the oversleeve portion of the connector and the winged portion of the connector together, aligning the grooves on the oversleeve portion of the connector with the barbs on the winged portion of the connector. Do not twist. Note: Connector portions must be gripped on plastic areas for proper assembly. Do not grip on distal (blue) portion of oversleeve. Advance completely until the connector barbs are fully attached. A tactile locking sensation will confirm that the two pieces are properly engaged. (There may be a small gap between the oversleeve and the winged portion of the connector).

- Aspirate and flush – attach primed extension set and or saline filled syringe.

- Attach primed extension set and / or saline filled syringe.

- Aspirate for adequate blood return and flush each lumen of the catheter with 10 cc of normal saline to ensure patency. Note: When infusion volume is a concern in small or pediatric patient’s flush with 3 cc per lumen.

- If the single lumen catheter will not aspirate and infuse immediately after insertion. If this situation persists, verify radiographically that the catheter is not kinked inside the vessel.

- Caution: To reduce potential for blood backflow into the catheter tip, always remove needles and needless caps slowly while injecting the last 0.5 cc of saline.
**SAMPLE POLICY & PROCEDURE**

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirate for adequate blood return and flush each lumen of the catheter with 10 cc of normal saline to ensure patency. Note: When infusion volume is a concern in small or pediatric patient’s flush with 3 cc per lumen. Note: If the single lumen catheter will not aspirate and infuse immediately after insertion and connector assembly, the catheter may be kinked within the connector assembly. If this is the case, trim the catheter just distal to the connector oversleeve (blue) and attach a new connector. If this situation persists, verify radiographically that the catheter is not kinked inside the vessel. Caution: To reduce potential for blood backflow into the catheter tip, always remove needles and needless caps slowly while injecting the last 0.5 cc of saline.</td>
<td></td>
</tr>
<tr>
<td>Verify placement (PICC only) – Verify catheter tip radiographically</td>
<td></td>
</tr>
<tr>
<td>Securing the Groshong® catheter: Suture wing near venipuncture. Place two anchor tapes over suture wing or bifurcation. Form “s” curve in catheter. Place 3rd anchor tape sticky side up under catheter just above suture wings or bifurcation. Chevron 3rd anchor tape on top of first (2) anchor tapes. Place transparent dressing over suture wing or bifurcation and catheter hub</td>
<td></td>
</tr>
<tr>
<td>Apply Stat-Lock® if used in accordance with manufacturer instructions under transparent dressing to secure catheter</td>
<td></td>
</tr>
<tr>
<td>Securing the Per-Q-Cath: Place S-Curve. Place 1st anchor tape over wings or bifurcation. Cover site and 1st anchor tape with transparent dressing up to hub, but not over hub. Place 2nd anchor tape sticky side up under hub and close to transparent dressing. Wedge tape between hub and wings. Anchor only one hub of dual lumen catheter. Chevron 2nd anchor tape on top of transparent dressing and place 3rd anchor tape over hub</td>
<td></td>
</tr>
<tr>
<td>Apply Stat-Lock® if used in accordance with manufacturer instructions under transparent dressing to secure catheter</td>
<td></td>
</tr>
</tbody>
</table>
**SAMPLE POLICY & PROCEDURE**

Micro-Introducer® Technique for all Groshong and Per-Q- Cath PICC Line and Midline Catheters

- Remove introducer needle cover
- Stabilize vein below intended access site with non dominant hand (unless using Site Rite® which is in non dominant hand)
- Grip only the introducer flashback chamber during the insertion
- Perform venipuncture using shallow technique 15 – 30 degree angle. For Site Rite® place introducer into needle guide and perform venipuncture. Use needle guide angle to guide needle puncture.
- After confirmation of blood return, lower introducer angle and advance approximately ¼ to ½ inches further to ensure positive cannulation of the vein.
- Holding the needle stationary, advance the introducer into the vessel by pushing forward. Stabilize introducer, release tourniquet.
- Support the introducer to avoid displacement. Apply slight pressure to the vessel above the insertion site to minimize blood flow. Release the tourniquet. Withdraw the needle from the introducer.
- Note: if using Protect-IV® from Johnson and Johnson follow manufacturer guidelines to activate safety mechanism. Push safety shield over needle until you hear an audible click.
- Apply pressure with nondominant hand over cannulated vein at tip of cannula to control bleeding and minimize blood exposure
- Insert the flexible end of the guidewire into the needle. Advance the guidewire as far as appropriate.
- Gently withdraw and remove the needle, while holding the guidewire in place.
- Using the surgical blade make a small nick alongside each side of the guidewire.
- Advance the small sheath and dilator together as a unit over the guidewire, using a slight ortational motion. Advance the unit intot he vein as far as appropriate.
- Withdraw the dilator and guidewire, leaving the small sheath in place.
- Insert the catheter through introducer (may use smooth non-groved pick-ups to advance the catheter). Advance the catheter slowly. For central placement (PICC only) when the tip has advanced to the shoulder, have the patient turn head (chin on shoulder) towards the insertion side to prevent possible cannulation into the jugular vein.
- Continue advancing catheter to measured point for PICC Line or Midline tip position. Catheter depth markings are in centimeters. (Arm at 90 degree angle) If difficulty is encountered, moving arm to shoulder height may ease passage. Warning: for PICC Line avoid positioning the catheter tip in the right atrium.
- Stabilize the catheter position by applying pressure to the vein distal to the introducer. Withdraw the introducer from the vein and away from the site. Split the sheath and peel it away from the catheter. For Groshong®: Remove the suture wing from the

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**SAMPLE POLICY & PROCEDURE**

<table>
<thead>
<tr>
<th>Procedure</th>
</tr>
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<tr>
<td>delivery card. Squeeze the suture wing together so that it splits open. Place the wing around the catheter near the venipuncture site. Caution Note: To minimize the risk of embolization the suture wing must be secured in place.</td>
</tr>
<tr>
<td>Per-Q-Cath® only – Disconnect the T-Lock from the catheter hub connector. Stabilize the catheter position by applying light pressure to the vein distal to the insertion site. Slowly remove the T-Lock and stylet.</td>
</tr>
<tr>
<td>Groshong® dual lumen – Stabilize the catheter position by applying light pressure to the vein distal to the insertion site. Slowly remove the stylet.</td>
</tr>
<tr>
<td>All catheters - Caution: Never use force to remove the stylet. Resistance can damage the catheter. If resistance or bunching of the catheter is observed, stop stylet withdrawal and allow the catheter to return to normal shape. Withdraw both the catheter and stylet together approximately 2 cm and reattempt stylet removal. Repeat this procedure until the stylet is easily removed.</td>
</tr>
<tr>
<td>Groshong® single lumen only: Modification of catheter length – Using a sharp scalpel or sterile scissors carefully cut the catheter leaving at least 4 cm – 7 cm of the catheter for connector attachment. Insect the cut surface to assure there is no loose material.</td>
</tr>
<tr>
<td>Attach connector to single lumen catheter – Retrieve the oversleeve portion of the connector and advance it over the end of the catheter. If you feel some resistance while advancing, gently twist back and forth or spin to ease its passage over the catheter. Gently advance the catheter onto the connector blunt until it butts up against the colored plastic body. The catheter should lie flat on the blunt without any kinks. With a straight motion slide the oversleeve portion of the connector and the winged portion of the connector together, aligning the grooves on the oversleeve portion of the connector with the barbs on the winged portion of the connector. Do not twist. Note: Connector portions must be gripped on plastic areas for proper assembly. Do not grip on distal (blue) portion of oversleeve. Advance completely until the connector barbs are fully attached. A tactile locking sensation will confirm that the two pieces are properly engaged. (There may be a small gap between the oversleeve and the winged portion of the connector).</td>
</tr>
<tr>
<td>vessel. Caution: To reduce potential for blood backflow into the catheter tip, always remove needles and needless caps slowly while injecting the last 0.5 cc of saline.</td>
</tr>
<tr>
<td>Attach primed extension set and / or saline filled syringe.</td>
</tr>
<tr>
<td>Aspirate for adequate blood return and flush each lumen of the catheter with 10 cc of normal saline to ensure patency. Note: When infusion volume is a concern in small or pediatric patient’s flush with 3 cc per lumen.</td>
</tr>
<tr>
<td>If the single lumen catheter will not aspirate and infuse immediately after insertion. If this situation persists, verify radiographically that the catheter is not kinked inside the vessel.</td>
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<tr>
<td>Caution: To reduce potential for blood backflow into the catheter tip, always remove needles and needless caps slowly while injecting the last 0.5 cc of saline.</td>
</tr>
<tr>
<td>Verify placement (PICC only) – Verify catheter tip radiographically.</td>
</tr>
<tr>
<td>Securing the Groshong® catheter: Suture wing near venipuncture. Place two anchor tapes over suture wing or bifurcation. Form “s” curve in catheter. Place 3rd anchor tape sticky side up under catheter just above suture wings or bifurcation. Chevron 3rd anchor tape on top of first (2) anchor tapes. Place transparent dressing over suture wing or bifurcation and catheter hub.</td>
</tr>
</tbody>
</table>

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- Securing the Per-Q-Cath: Place S-Curve. Place 1st anchor tape over wings or bifurcation. Cover site and 1st anchor tape with transparent dressing up to hub, but not over hub. Place 2nd anchor tape sticky side up under hub and close to transparent dressing. Wedge tape between hub and wings. Anchor only one hub of dual lumen catheter. Chevron 2nd anchor tape on top of transparent dressing and place 3rd anchor tape over hub.
- Apply Stat-Lock® if used in accordance with manufacturer instructions under transparent dressing to secure catheter.

23. Prior to initiation of therapy, radiographically confirm that the catheter tip is in the superior vena cava (PICC Line only).

24. Initiate prescribe therapy.

25. Discard expended equipment in appropriate receptacles with universal precautions in mind.

26. Document in patient’s medical record: Time, date, length of entire catheter, the amount of catheter remaining outside of insertion site, trimmed length (if applicable), name of vein, mid upper arm circumference (optional), location of catheter tip, verification of catheter tip placement (PICC Line only), patient instruction and response to procedure, catheter lot number, brand, gauge, number of lumens, right or left arm, description of sterile prep, complications if any during insertion, contraindications to use of line if any, precautions if any, number of attempts, date of insertion, informed consent with patient verbalization, any care and maintenance needs, PICC Line or Midline catheter.

27. Report to staff any complications that occurred during placement and expected patient criteria to monitor.

28. See basic care and maintenance table.

**Basic Care & Maintenance:**

<table>
<thead>
<tr>
<th>Action</th>
<th>Timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Catheter dressing change</td>
<td>24 hours</td>
</tr>
<tr>
<td></td>
<td>- Assess the dressing in the first 24 hours for accumulation of blood, fluid or moisture beneath the dressing. During the dressing changes, assess the external length of the catheter to determine if migration of the catheter has occurred. Periodically confirm placement of tip location, patency, and security of dressing.</td>
</tr>
<tr>
<td>Dressing changes after first change at 24 hours</td>
<td>7 days or PRN if damp, loosened, or soiled</td>
</tr>
<tr>
<td></td>
<td>- During the dressing changes, assess the external length of the catheter to determine if migration of the catheter has occurred. Periodically confirm placement of tip location, patency, and security of dressing.</td>
</tr>
</tbody>
</table>
## SAMPLE POLICY & PROCEDURE

| Injection cap change                                                                 | ✗ Every seven days (about 18 needle insertions).  
|                                                                                      | ✗ When the cap has been removed for any reason  
|                                                                                      | ✗ Anytime the cap appears damaged, is leaking, blood is seen in the catheter without explanation, or blood residue is observed in the cap  
|                                                                                      | ✗ After blood withdrawal through the injection cap  
| Blood sampling                                                                      | ✗ 10 cc positive pressure fluid flush of sterile 0.9% sodium chloride (for open Per-Q-Cath products utilize heparin after saline)  
|                                                                                      | ✗ Change injection cap  
| Catheter irrigation / flushing                                                       | ✗ Groshong (only) every seven days or after IV administration of TPN, IV fluids, or medications. 10 cc syringe filled with 5 cc of sterile 0.9% sodium chloride. (use positive pressure flush)  
|                                                                                      | ✗ Per-Q-Cath (only) every 12 hours or after IV administration of TPN, IV fluids or medications. 10 cc syringe filled with 1 cc of sterile 0.9% sodium chloride and heparin in accordance with institution policy. (use positive pressure flush)  
| Repair                                                                              | ✗ Groshong single lumen catheter may be permanently repaired by following procedure of placement of a catheter hub in insertion policy  
|                                                                                      | ✗ Per-Q-Cath can be repaired using a Per-Q-Cath repair kit, however, the repair kit only exists for certain catheter sizes.  
| Blood occlusion                                                                     | ✗ Utilize thrombolytic agent  

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Purpose:

To prevent external infection of the peripheral or central venous catheter

Frequency:

Assess the dressing in the first 24 hours (change) for accumulation of blood fluid or moisture beneath the dressing. After the first 24 hours the frequency is every seven days and PRN (as needed) if dressing is loose, damp, or soiled.

Supplies:

Sterile dressing kit or sterile supplies:
- (3) Isopropyl alcohol swabsticks (Caution – do not use with polyurethane Per-Q-Cath® PICC Line or Midline catheters due to potential for catheter damage)
- (3) Providone-iodine swabsticks
- (2) 2 in. x 2 in. gauze – Optional
- (1) 10 x 12 transparent dressing
- (1) Pair sterile gloves / (1) Pair clean gloves
- (2) Masks (patient may wear mask if they can tolerate)
- (1) Protective eyewear or shield depending on hospital policy
- Sterile gown (optional – full barrier precautions)
- Stat-Lock® securement device (optional)
- Injection cap / extension set / T-Port (optional)

Procedure:

1. Identify patient assess patient’s chart for any signs, symptoms of complications related to his/her vascular access device

2. Question patient about any concerns over their catheter or experience. Explain procedure to patient

3. Wash hands

4. Don clean gloves and carefully remove the old dressing and discard in accordance with blood and body fluids and universal precautions. Avoid tugging on the catheter, or use of scissors, or other sharp objects near the catheter.
SAMPLE POLICY & PROCEDURE

5. Inspect the exit site for swelling, redness, exudate. During all dressing changes assess the external length of the catheter to determine if migration of the catheter has occurred. Periodically confirm catheter placement, tip location, patency, and security of dressing. Notify physician if any problem observed.

6. Wash hands thoroughly

7. Put on new pair of sterile gloves

8. Using friction clean the catheter exit site with an alcohol swabstick starting at the exit site and spiraling outward until a circle at least 2 inches in diameter has been prepped (Caution do not use alcohol products on polyurethane Per-Q-Cath® products). Do not return to the catheter exit site with the same swabstick. Repeat with the remaining two swabsticks. Allow antiseptic to air dry (i.e. do not blow or blot dry)

9. Using friction clean the catheter exit site with a providone-iodine swabstick starting at the exit site and spiraling outward until a circle at least two inches in diameter has been prepped. Do not return to the catheter exit site with the same swabstick. Repeat with the remaining two swabsticks. Allow providone-iodine to dry at least two minutes.

10. Optional if used – Change Stat-Lock®, injection cap, extension set, T-Port when dressing is changed

11. Apply transparent dressing according to manufacturer’s recommendations

12. Position sterile dressing over insertion site, catheter tubing and hub. Tape over the winged connector for added securement, if desired.

13. Gently smooth dressing from center toward edge; do not apply excessive tension to skin shearing may result

14. Avoid sealing transparent dressing edges with tape

15. Do not cover dressing with roller bandage

16. Change dressing immediately if integrity is compromised, and / or if there is excessive drainage or moisture

17. Note: When a transparent semipermeable membrane is applied over gauze, it is considered a gauze dressing in accordance with the Intravenous Nursing Society Standards and must be changed every 48 hours,
SAMPLE POLICY & PROCEDURE

Policy and Procedure
Flushing and / or Blood withdrawal – Aspiration Procedure
For PICC Line and Midline Catheters

Purpose:

Blood Withdrawal:

- To obtain blood samples for laboratory evaluation, eliminating the need for peripheral vein puncture
- To verify venous placement prior to administration of hypertonic or vesicant solutions
- Note: If you encounter difficulties with blood withdrawal see troubleshooting guide-aspiration difficulties “Bard Access Systems Groshong Peripherally Inserted Central Venous Catheter (P.I.C.C.) Nursing Procedure Manual”

Catheter Irrigation / Flushing

- To maintain patency
- Prevent mixing of medications and/or solutions that are incompatible

Routine flushing shall be performed with the following:

- Administration of blood
- Blood sampling
- Administration of incompatible medications or solutions
- Administration of medication
- Intermittent therapy
- When converting from continuous to intermittent therapies

Supplies:

- Isopropyl alcohol (Note: do not use on body of polyurethane Per-Q-Cath®) and / or providone-iodine wipes
- 10 cc syringe filled with 5 cc of sterile 0.9% sodium chloride (normal saline) – flush
- 10 cc syringe filled with 10 cc of sterile 0.9% sodium chloride (normal saline) – blood withdrawal
- Injection cap (blood withdrawal)
- 1 in needle or needless adapter
- Heparin solution in 10 cc syringe barrel in accordance with institution policy for Per-Q-Cath® catheters
- Gloves / sharps container
- Blood specimen tubes
- Vacuum blood collection needless device
SAMPLE POLICY & PROCEDURE

- Needless transfer devices

Procedure:

1. Identify patient assess patient’s chart for any signs, symptoms of complications related to his/her vascular access device

2. Question patient about any concerns over their catheter or experience. Explain procedure to patient

3. Wash hands

4. Don gloves. Use aseptic technique and observe standard blood and body fluid precautions and universal precautions throughout procedure

5. Clean injection cap with alcohol or providone-iodine wipe

6. Note: If resistance or complication occurs at any time during flushing, discontinue and notify physician

<table>
<thead>
<tr>
<th>Groshong PICC and Midline Saline only flush</th>
<th>Per-Q-Cath PICC and Midline Saline and heparin flush</th>
<th>Groshong PICC and Midline Blood withdrawal Hub to Hub Per-Q-Cath PICC and Midline Blood withdrawal</th>
<th>Groshong PICC and Midline Per-Q-Cath PICC and Midline Blood withdrawal Needle to needless adapter through injection cap (vacuum blood collection system or syringe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Connect saline-filled syringe to cannula via insertion into prepared cap or needless device</td>
<td>Connect saline-filled syringe to cannula via insertion into prepared cap or needless device</td>
<td>Draw up 10 cc normal saline in syringe and set aside 0.9% sterile sodium chloride solution. If TPN is infusing draw up 20 cc of normal saline</td>
<td>Draw up 10 cc normal saline in syringe and set aside 0.9% sterile sodium chloride solution. If TPN is infusing draw up 20 cc of normal saline</td>
</tr>
<tr>
<td>Bard Access System note: If blood is aspirated prior to infusion of medications(to</td>
<td>Insert needle or needless adapter on syringe filled with 1 cc of sterile 0.9% chloride (normal</td>
<td>Stop any IV fluids infusing through the catheter including another lumen of the catheter. Remove</td>
<td>Stop any IV fluids infusing through the catheter including another lumen of the catheter. Remove</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Sample Policy &amp; Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Verify Venous Placement</strong>, catheter should be irrigated with 10 cc of normal saline prior to attaching medication, syringe, IV or infusion pump tubing. Failure to do so may result in an occluded catheter, leading to difficulty in aspirating in the future.</td>
</tr>
<tr>
<td><strong>Cap/I.V. tubing from catheter hub. Clean catheter hub with alcohol and /or providone-iodine. Attach an empty 10-cc syringe to catheter hub. Pull back syringe plunger 1-2 cc, pausing for 2 seconds to allow catheter valve to open and blood to come into the catheter. Slowly continue to aspirate 5 cc of blood.</strong></td>
</tr>
<tr>
<td><strong>Cap/I.V. tubing from catheter hub. Clean catheter hub with alcohol and /or providone-iodine. Attach an empty 10-cc syringe to catheter hub. Pull back syringe plunger 1-2 cc, pausing for 2 seconds to allow catheter valve to open and blood to come into the catheter. Slowly continue to aspirate 5 cc of blood.</strong> Note: A vacuum collection specimen tube may be used to withdraw the discard sample but be sure to use one with at least 5 cc capacity.</td>
</tr>
</tbody>
</table>

| Insert needle or needless adapter on syringe filled with 5 cc of sterile 0.9% saline (normal saline) into injection cap or needless system. |
| **Connect heparin filled syringe to injection cap with needle or needless system.** |
| **Disconnect syringe and discard (saline in catheter dilutes specimen and may alter lab values). Clean injection cap with alcohol / providone-iodine wipe.** |
| **Disconnect syringe and discard (saline in catheter dilutes specimen and may alter lab values). Clean injection cap with alcohol / providone-iodine wipe.** |

| Slowly inject flush maintaining positive pressure (infusing last 0.5 cc as the needle or needless adapter is withdrawn from the injection cap. (Helps prevent vacuum which can pull a small amount of) |
| **Slowly inject flush maintaining positive pressure (infusing last 0.5 cc as the needle or needless adapter is withdrawn from the injection cap. (Helps prevent vacuum which can pull a small amount of)** |
| **Attach empty syringe 10 cc syringe and aspirate by pulling back plunger 1-2 cc pausing for 2 seconds to allow the catheter valve to open and blood to come into the catheter. Slowly** |
| **Insert vacuum blood collection system needle or needless adapter into the injection cap. Push blood specimen tube into vacuum collection device sleeve so that rubber stopper is pierced. Blood needed for** |
## SAMPLE POLICY & PROCEDURE

<table>
<thead>
<tr>
<th>blood into tip of catheter)</th>
<th>blood into tip of catheter)</th>
<th>continue to withdraw amount of blood needed for testing</th>
<th>specimen will flow into specimen tube. Change tubes as needed for required tests.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disconnect syringe and attach saline filled syringe. Flush the catheter with 10 cc normal saline. Slowly inject flush maintaining positive pressure (infusing last 0.5 cc as the needle or needless adapter is withdrawn from the injection cap. (Helps prevent vacuum which can pull a small amount of blood into tip of catheter))</td>
<td>Clean injection cap with alcohol and / or providone-iodine wipe. Insert needle or needless adapter of saline-filled syringe and flush the catheter with 10 cc of normal saline</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attach new injection cap or needleless system</td>
<td>Slowly inject flush maintaining positive pressure (infusing last 0.5 cc as the needle or needless adapter is withdrawn from the injection cap. (Helps prevent vacuum which can pull a small amount of blood into tip of catheter))</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attach 1 in needle or needleless adapter to blood sample syringe to transfer to blood collection tubes</td>
<td>If unable to flush all of the blood residue out of the injection cap, attach a new sterile injection cap.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Flush guidelines for small patients:

1. Use the same procedure as for adults with the following exceptions:
   - Use 2 cc normal saline for routine maintenance (Groshong) every seven days; or after IV administration, TPN, IV fluids, or medications
   - Use heparin solution (Per-Q-Cath) in accordance with institutional policy
   - Use 3 cc normal saline after blood aspiration for any reason, or when blood is observed in the catheter. Note: This amount is insufficient to clear blood from an injection cap. The injection cap should be changed following blood withdrawal
Policy and Procedure for Clearing Occluded PICC Line and Midline Catheters

Purpose:

To restore patency to a catheter with a blood or chemical occlusion

Supplies:

(1) Sterile injection cap or needleless system
(1) Thrombolytic agent
(3) 10 cc syringe with attached 1 in. needle or needleless adapter
(1) 10 cc sterile normal saline filled syringe with attached 1 in needle or needleless adapter
- Isopropyl alcohol wipes
(1) Stopcock – 3 way

Procedure:

1. Notify physician immediately of suspected catheter occlusion and type of occlusion (i.e. blood, chemical precipitate)

2. Obtain treatment orders for thrombolytic agent. Cautions contained in medication package insert should be observed

3. Review patient chart for allergies, medical history & condition, lab coagulation studies, and contraindications to procedure

4. Explain procedure to patient and obtain patient informed consent

5. Wash hands and glove and any personal protective equipment needed

6. Use aseptic technique and observe blood and body fluid precautions and universal precautions

7. Remove injection cap, attach an empty 10-cc syringe and attempt to aspirate. If aspiration is successful withdraw clots and flush. If aspiration is unsuccessful proceed forward

8. Document procedure in patients medical record upon completion of one of the two methods
SAMPLE POLICY & PROCEDURE

Two Methods available: Syringe and Stopcock Method

<table>
<thead>
<tr>
<th>Syringe Method Declotting</th>
<th>Stopcock Method Declotting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Draw up thrombolytic agent into a 10 cc syringe to equal the internal volume of the catheter (volume may be reduced if catheter length has been altered)</td>
<td>Attach stopcock to cannula hub. Turn stopcock to off position. Unclamp catheter.</td>
</tr>
<tr>
<td>Aseptically attach thrombolytic filled syringe to the catheter hub. Slowly and gently inject the thrombolytic agent using a push-pull motion to achieve maximum mixing. To avoid catheter rupture do not force entire amount into catheter if strong resistance is felt</td>
<td>Connect empty syringe to one port of stopcock. Connect syringe filled with thrombolytic agent to second part of stopcock.</td>
</tr>
<tr>
<td>Leave 10-cc syringe attached to catheter. Do not attempt to aspirate for 30 - 60 minutes</td>
<td>Open stopcock port connected to empty syringe. Gently aspirate empty syringe to 8-9 cc, then close port, creating negative pressure</td>
</tr>
<tr>
<td>After 30 – 60 minutes attempt to aspirate 5 ml of blood to assure removal of all drug and clots</td>
<td>Open stopcock port connected to syringe filled with thrombolytic agent. Gently inject thrombolytic agent into catheter. Do not force.</td>
</tr>
<tr>
<td>Remove blood-filled syringe and replace it with a 10-cc syringe filled with normal saline. Flush catheter to verify patency</td>
<td>Close stopcock to catheter. Secure device to patient and label “Do not use” Allow agent to dwell in catheter for 30 – 60 minutes</td>
</tr>
<tr>
<td>Attach sterile, saline-filled injection cap or needleless device</td>
<td>Open stopcock to catheter aspirate 3-5 cc of blood and discard. Flush with 10 ml of 0.9% sterile sodium chloride. Attach sterile, saline-filled injection cap or needleless device</td>
</tr>
</tbody>
</table>

If unable to aspirate, repeat procedure, If unsuccessful notify physician

If unable to aspirate, repeat procedure, If unsuccessful notify physician

Note:

- For suspected lipid deposition occlusion when a thrombolytic does not clear the blockage, a sterile Ethanol 70% solution may be instilled and left in place for one hour. Follow above procedure for thrombolytic agent
- For suspected calcium and phosphate precipitation when a thrombolytic does not clear the blockage, a sterile 0.1% N Hydrochloric Acid solution may be instilled and left in place for one hour. The solution is then aspirated and the catheter flushed with normal saline. Follow above procedure for thrombolytic agent
This may help to clear the catheter of calcium phosphate or other drug precipitates. Sodium bicarbonate may also be used for precipitates that are soluble in a basic solution.
SAMPLE POLICY & PROCEDURE

Policy and Procedure Catheter Removal for
PICC Line and Midline Catheters

Policy:

A physician order is required to remove a PICC Line. (Midline catheters being a peripheral catheter are removed when there is evidence of peripheral complications or the end of infusion therapy

A PICC Line or Midline catheter can be removed by a qualified Registered Nurse who has successfully completed competency in removal and understands emergency and complication management

Supplies:

Sterile 4 x 4
Tape
Gloves
Antibiotic Ointment

Procedure:

1. Review patient’s chart for any contraindications to removing the patient’s PICC or Midline catheter
2. Obtain physician order for PICC Line removal only
3. Explain procedure to patient and obtain informed consent
4. Remove dressing and discard
5. Assess insertion site
6. Grasp catheter near insertion site and remove slowly. Do not use excessive force
7. Use a gentle steady motion to prevent catheter damage going back to insertion site each time.
8. If resistance is felt, stop removal. Apply warm compresses and wait 20-30 minutes
9. Resume removal process. Should the catheter embolize during the removal process, tie a tourniquet around the upper arm and immediately contact a physician regarding this emergency situation
10. If catheter continues to resist removal notify physician

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11. After removal, apply pressure to site and 4 x 4 gauze until bleeding stops.

12. Place sterile 4 x 4 gauze dressing on site

13. Examine catheter tip for any indication of incomplete removal. Compare measurement taken out to insertion measurement. Notify physician immediately if there is a problem

14. Document procedure in patient’s chart
Policy and Procedure PICC Line and Midline Repair
For Groshong Single Lumen Catheters Only

Purpose:

To repair a damage or loose connector

Note: Catheter should have been clamped with an atraumatic non-toothed clamp or kinked and taped between the catheter exit site and the damaged area when damage or connector separation occurred and must remain clamped or kinked and taped during repair.

Supplies:

Replacement connector (3Fr. - #7712300 – forest green) (4 Fr. - #7712400 – gray)
Isopropyl alcohol wipes
Providone-iodine wipe
Sterile Scissors
Sterile Gloves
10 cc syringe attached 1 in. needle or needleless adapter filled with 5 cc sterile 0.9% sodium chloride (normal saline)

Procedure:

1. Review patient’s chart for length of IV therapy and any contraindications associated with catheter Repair
2. Explain procedure to patient and obtain informed consent
3. Wash hands
4. Obtain a new sterile replacement connector of the correct size
5. Determine where the damaged catheter is to be cut off. Do not cut at this time. Be sure to retain as much of the original external segment as possible. At least 2 in. of intact catheter beyond the skin exit site is needed to be able to repair the catheter
6. Thoroughly clean the catheter with alcohol and providone-iodine wipes at the point where it is to be cut
7 Wearing sterile gloves and using sterile scissors, cut the catheter at a 90 degree angle, ½ inch distal to the location of the previous connector or damaged site to remove any damaged catheter material.

8 Retrieve the oversleeve portion of the connector and advance it over the end of the catheter. If you feel some resistance while advancing the oversleeve, gently twist back and forth or spin to ease its passage over the catheter.

9 Gently advance the catheter onto the connector blunt until it butts up against the colored plastic body. The catheter should lie flat on the blunt without any kinks.

10 With a straight motion, slide the oversleeve portion of the connector and the winged portion of the connector together, aligning the grooves on the oversleeve portion of the connector with the barbs on the winged portion of the connector. Do not twist.

11 Note: Connector portions must be gripped on hard plastic areas for proper assembly. Do not grip distal (blue) portion of oversleeve.

12 Advance completely until the connector barbs are fully attached. A tactile locking sensation will confirm that the two pieces are properly engaged. (There may be a small gap between the oversleeve and the winged portion of the connector.)

13 Attach syringe to connector and aspirate blood to confirm patency. Irrigate the catheter with 10-cc normal saline solution. Attach pre-filled injection cap or I.V. tubing.

14 Note: When infusion volume is a concern in small or pediatric patients, irrigate the catheter with 3 cc of sterile normal saline in a 10 cc syringe.

15 Document the repair in the patient’s chart.
OUTCOMES MONITORING

As nursing practice has become more scientifically based, the emphasis on evidence-based and quantitative practice has increased. This is as true for PICCs as it is for any other aspect of nursing practice. It is important to monitor how well vascular devices are performing, whether or not the therapy was completed without complications, and the patient’s level of satisfaction with this mode of treatment.

The effectiveness of vascular access devices, whether or not therapy was completed without complications and the patient’s level of satisfaction all translate into the quality of care rendered to this patient. The age old question of how we measure quality and what quality indicates comes to mind. In reality quality indicators don’t measure quality, they point to problem areas that need improvement—the entire point of a quality improvement system. “A valid measure of quality specifically identifies an aspect of care where there is a known problem and describes the extent of the problem. Quality measures are definitive end points that do not require future investigation in order to make judgements about quality of care.”

So how are quality indicators determined? The most definitive method is through the collection of data that can be reviewed for trends. These trends are then studied and a plan of action developed to address those trends that could improve the quality of care patients are receiving. Bard Access Systems has developed several tools that can be used as they are or as guidelines for developing hospital specific tools. Samples follow.

If you should decide to develop your own outcome monitoring tools, remember that all quality indicators should address the following:

♦ Address current clinical knowledge and technology
♦ Be predetermined and agreed to by all involved practitioners in advance of data collection and measurement
♦ Be consistent and reflect current internal policies, procedures and protocols as well as external rules and regulations
♦ Reflect standards

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1 Advance for Nurses, “Quality Indicators”, July 31, 2000, vol 2 no. 15, pg 23

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SAMPLE POLICY & PROCEDURE

BARD ACCESS SYSTEMS
VASCULAR ACCESS DEVICE INSERTION/ PATIENT OUTCOME FORM
ASSESSMENT FLOW PROCESS

Patient Name: __________________________ Pt. Room # ________ Pt. Sex ________

Pt. Diagnosis: ______________________________________________________________________

VAD Assessor Name: __________________________________________________________________

VAD Selected: ____________________________ Reason: ______________________________________________________________________

Comments: ______________________________________________________________________

Device Placed On (Date) ________ Where Placed: _________________________________

Who Placed Device? _____________________________________________________________

(If Device Not Placed, Why?) ______________________________________________________________________

Insertion Complications: _______ Yes _______ No

Comments: ______________________________________________________________________

TO BE COMPLETED WHEN DEVICE IS REMOVED OR PATIENT IS DISCHARGED WITH
DEVICE (Prior to discharge)

Pt. Name: __________________________ Pt. Age ________ Pt. Sex ______ Pt. Room # ______

Pt. Adm. #: ____________ Pt. Diagnosis: ______________________________________________________________________

Vascular Access Device Removed ______ Yes ______ No ______ Date _____________

Reason for Device Removal: _______ End of Therapy ______ Complication
__________________________ Infection ________ Leakeage ________ Patient Death ______ Thrombosis
__________________________ Occlusion ________ Breakage ________ Phlebitis ________ Pt. Pulled Out
__________________________ Other (Specify)

Complications During Device Removal ______ Yes ______ No

Specify ________________________________________________________________

Device Removed By ______________________ Date ______ Where ______________________

SEND FORM TO QUALITY ASSURANCE

INSTRUCTIONS:
IF PATIENT IS DISCHARGED WITH VAD, FILL OUT THIS FORM AND SEND A BLANK FORM
WITH THE PATIENT. INSTRUCT THE PATIENT TO HAVE THEIR AGENCY COMPLETE THE
FORM AND SEND TO THE HOSPITAL QUALITY ASSURANCE DEPARTMENT. IF THE
AGENCY IS WITH THE HOSPITAL, PASS ALONG A BLANK FORM.
SAMPLE POLICY & PROCEDURE

BARD ACCESS SYSTEMS
VASCULAR ACCESS PATIENT SATISFACTION FORM
PATIENT OUTCOME PROCESS

Patient completes form prior to discharge or upon I.V. removal

Patient Name ________________ Pt. Room # ____ Pt. Sex _____ Pt. Adm. Date ____

Were you satisfied with the I.V. device placed? ______ Yes ______ No
If no, why? ______________________________________________________________

Were you satisfied with the person placing the I. V. ? ______ Yes ______ No
If no, why? ______________________________________________________________

Was this a _____ Physician _____ Nurse _____ Other

Was the I.V. insertion ______ Painful? ______ Uncomfortable?

How many times did they stick you? ______ Sticks

Explain (If the stick was painful/uncomfortable) _________________________________

Is this the first time you have had an I.V. device placed ______ Yes ______ No
If no, what type of I.V. have you had before __________________________________

Patient Teaching:

Did you fully understand: what the I.V. is used for? ______ Yes ______ No

how the I.V. is placed? ______ Yes ______ No

What the complications are? ______ Yes ______ No

If no, what did you not understand? __________________________________________

Overall, did you find that the I.V. therapy was to your satisfaction? ______ Yes ______ No

If No, Why? ______________________________________________________________

Comments ______________________________________________________________