Policy Compliance Procedure

Title: Central Venous Access Devices (CVAD): Care and Management

Document Number: LH_PCP2015_C03.16

Governing Policy: NSW Health Policy PD2011_060 Central Venous Access Device Insertion and Post Insertion Care

Approved by: Director of Medical Services
General Manager

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Related Standards

- Standard 4 Medication Safety & Administration
- Standard 3 Preventing Controlling Healthcare Infections
- Standard 5 Patient Identification & Procedure Matching

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Staff are referred to the NSW Health Policy PD2011_060 Central Venous Access Device Insertion and Post Insertion Care to be read in conjunction with the Liverpool CVAD and related documents.

Related Liverpool Policies/Procedures:

- C03.17 Central Venous Access Devices Insertion Guidelines
- C03.18 Removal of Central Venous Access Devices (CVAD)
- C03.62 Indwelling Venous Access Device (Portacath)
- C06.03 Hand Hygiene
- C06.32 Aseptic Technique
1. Liverpool Specific Procedures

Neonatal patients must be managed as per Neonatal Intensive Care guidelines.

1.1 Accreditation Requirements
- Care and management of central venous access devices (CVAD) will be in accordance with the NSW Health PD2011_060 Central Venous Access Device Insertion and Post Insertion Care and Liverpool Hospital specific procedures.
- Registered Nurses / Midwives and Enrolled Nurses may attend to general care of the CVAD and are required to be accredited for CVAD dressing and administration set change and taking blood. Details in Appendix 6
- The CNC for Central Venous Access and Parenteral Nutrition can be contacted on Ext 83603 or Pager #48886.

1.2 General Care
- Applies to both short and long term central venous catheters. These include:
  - Central tunnelled or non-tunnelled catheters
  - Single or multiple lumen catheters
  - Percutaneous Haemodialysis/ Aphaeresis catheters (multiple lumen)
  - Peripherally Inserted Central Catheters (PICC): Single or multiple lumen
  - Femoral Catheters: Single or multiple lumen catheters
- Each CVAD must be assessed on each shift and when ever infusions are changed or commenced for signs of inflammation and infection whilst leaving dressing intact. If the dressing or administration sets require changing or additional securement see specific section below.
- Apply personal protective equipment whilst handling a CVAD: apron, protective eyewear and gloves.
- For administration of medication refer to Liverpool Policy C03.01 Drug Administration Policy
- A needle Free Access device (bung) should be applied to all lumens of the CVAD
- Prior to accessing any device, the lumen or needle free access device shall be cleaned using a vigorous scrubbing action ("Scrub the Hub' principle) for 15 seconds using 2% Chlorhexidine Gluconate in 70% Isopropyl Alcohol or plain isopropyl alcohol, swab/soaked gauze.
- Povidone-Iodine recommended as a skin decontaminant for patients with chlorhexidine allergy
- Check expiry dates on all products used

1.3 Dressings
- Only accredited Nursing/ Midwifery staff or a Medical Officer can change the dressing
- Re-dress and clean the catheter site weekly, or immediately if the dressing is soiled or becomes moist or non-occlusive/unsecured (See Appendix 2 for examples of dressings and securement devices).
- Date the dressing (date of change) and document insertion site condition and procedure in health care record.
- Central venous access device (CVAD) stabilization shall be used to preserve the integrity of the access device, minimize catheter movement at the hub, and prevent catheter dislodgment and loss of access.
- Measure external length of catheter before and after dressing change using the printed markings on the catheter or by using a tape measure to ensure catheter has not been displaced during procedure. Document measurements in the patient’s health care record.
- If catheter has moved greater than 3cm from initial insertion depth (depth documented on the Central Venous Access Insertion Form on eMR or Central Venous Line Insertion Record - SMR090.200 form), stabilise at the point of external
migration and contact the CNC Central Venous Access and PN, or CNC After Hours or ICU Registrar on duty after hours. If the catheter is suspected to be out of the vein, turn off infusions and wait for medical assessment of CVAD placement before further use.

- A catheter that migrates externally **must not** be re-advanced into the vein. A CXR is warranted to verify catheter tip location if migration has occurred when TPN or known vesicants / irritants are in use.
- Generally, PICC lines are not sutured and are held in place by the non-suturing securement device, the dressing, and any steri-strips (if used). Care must be taken not to dislodge the catheter when attending dressing changes and removing any securement devices and accessories.
- Secure the catheter to the skin in such a way to avoid kinking of the catheter.
- If sutures used to stabilize a CVAD at placement become loose or no longer intact, they should be removed and the CVAD should be secured using another stabilization method or resutured as appropriate by CNC CVAS or Medical Officer.
- Specific infusions may continue when re-dressing lines e.g. Chemotherapy, anticoagulation or inotropes infusions.

### 1.4 Infusion Administration Set Changes

- Administration set changes shall be performed routinely, based on factors such as type of solution administered, type of the infusion (continuous versus intermittent), immediately upon suspected contamination, or when the integrity of the product or system has been compromised.
- Change infusion administration sets and burettes every 7 days or in conjunction with weekly dressing changes depending on the type of infusion.
- Administration sets that have infused blood products, lipid emulsions or specific infusions such as Glyceryl Trinitrate or Cytotoxic must be changed at least every 24 hours (this includes TPN) or as recommended by the manufacturer. Refer to **SWSLHD_PD2013_045 Administration of Blood Products** Policy.
- Administration sets must not be transferred between different lumens of the CVAD and must be discarded and replaced if they are disconnected.
- The administration set shall be changed whenever a new central vascular access device is inserted.
- Add-on devices used as part of the administration set, such as single- and multi-lumen extension sets and filters, shall be changed at the same time as the administration set (Used in critical care areas only).
- Security of connections between add on devices and the CVAD lumen should be checked each time the device is accessed and as part of routine assessment.
- A vented administration set shall be used for solutions supplied in glass or semi-rigid containers, and a non-vented administration set shall be used for plastic fluid containers.
- Administration set labels must be used to identify the administration set and used for specific medications when running a dedicated, continuous or intermittent infusion. Always ensure the medication label is removed on completion of infusion. (Appendix 4) Refer to **LH_PD2013_C03.12 Intravenous (IV) Therapy and Medication Administration** for further information
- All infusion administration sets must be secured to the patient to prevent tension on the insertion site and dressing, and/or accidental removal.

### 1.5 Maintenance of Device Patency

- The accredited clinician will flush using a pulsatile push pause-push and positive pressure method also known as the positive pressure pulsatile flush. (See Appendix 5)
- Catheters will be flushed with 0.9% Sodium Chloride for injection (10-20mls) using a positive pressure pulsatile technique), with a 10ml syringe prior to and following
administration of infusates and blood collection (at least 20ml flush after blood collection)

- Where a patient is receiving maintenance fluids only the catheter will be flushed using the same technique, via the administration set side port once per shift.
- The clinician should assess for and identify signs of CVAD occlusion, including the inability to withdraw blood, sluggish flow, and/or inability to flush or infuse through the device. The catheter should not be forcibly flushed.
- If resistance is met and if unable to aspirate blood, flush the lumen GENTLY using a 10mL syringe or larger with 0.9% Sodium Chloride for injection. Notify the CNC, Central Venous Access and PN via phone/pager if resistance to flushing is felt. If after hours, contact the ICU Registrar on duty.
- Utilise the SAS principle for medication administration i.e. Saline flush, Administer medication followed by Saline flush.
- Single-use systems, including single-dose vials and prefilled syringes, are the preferred choices for flushing and locking.
- Vascular access devices shall be locked after completion of the final flush solution to decrease the risk of occlusion.
- Unused Lumens will be locked with 0.9% Sodium Chloride for injection 10mL per lumen or Heparin /Heparinised Saline 50 units in 5 ml if prescribed by the Medical staff (approximately 2 ml per lumen).
- Lumens not in use should be locked weekly.
- NB: Where a negative displacement IV connector is used, clamping of lumen is required whilst flushing. For neutral connectors clamping of lumen is optional. For positive displacement connectors clamping of lumen is not required.
- Heparin 5000 units in 5mls is used for locking vascaths only. The volume required is specified on the lumen (No more than 2mls)

2. Procedure Steps

2.1 Dressing/Administration set Change:

**Equipment**

- Dressing trolley
- Dressing pack
- Chlorhexidine 0.5% or 2% in isopropyl alcohol 70% swabs. (2% is preferred)
- Antimicrobial dressing (e.g. Biopatch/Tegaderm CHG)
- Sterile Semi-permeable transparent dressing (e.g. IV3000/Tegaderm)
- Skin protective barrier wipe single use sterile swab
- Plastic apron, mask, protective eye wear, sterile gloves
- Non suturing securement device
- Paper tape measure

**If Performing Administration Set Change**

- New infusion administration sets and intravenous fluids as per prescription on Fluid order chart
- New needless connector (bung)

*If performing the dressing change only, omit steps 7 and 23-25.*

1. Assess function and need for CVAD
2. Explain procedure to patient and position patient comfortably.
3. Ensure bed is at the right height for your back.
4. Collect equipment and set up work area space.
5. Wash hands using skin antiseptic – as per Liverpool Policy C06.03 Hand Hygiene
6. Wear protective apron, mask and eyewear
7. Prime new IV administration sets.
8. Measure external length of catheter using the printed markings on the catheter or by using a paper disposable tape measure
9. Remove existing dressing and securement device and check site.
10. Removes any unnecessary attachments.
11. If site is red, inflamed or there is purulent drainage, swab site and send for culture and 
sensitivity and notify CNC - Central Venous Access and PN and Treating Team; after 
hours contact ICU Registrar/after hours CNC for review
12. Clean insertion site with Chlorhexidine 0.5% or 2% in alcohol 70% (0.5% Solution or 2% 
Swab sticks) and allow drying.
13. Wash hands and apply sterile gloves.
14. If using Protective Barrier wipe/swab on the skin to protect against reaction to dressing 
and improve adhesion, use as per manufacturer’s instructions. Must be allowed to dry 
correctly prior to applying the dressing.
15. Apply large steri-strips to catheter if additional securement required.
16. Apply antimicrobial dressing at insertion site
17. Position catheter and attach non-suturing anchoring device to catheter. (See Non-
Suturing Device Application in Appendix 2.)
18. If non-suturing anchoring device is not available, use large steristrips to secure the 
catheter to the skin and replace with securement device as soon as possible.
19. Ensure CVAD is secured in at least 2 places with the first close to the insertion site
20. Apply sterile semi-permeable transparent dressing.
21. Measure external catheter length and record. If a difference greater than 3cm is found, 
stabilise at the point of external migration and contact CNC Central Venous Access and 
PN, or ICU Registrar on duty after hours.
22. When changing infusion administration sets, lay patient flat unless contraindicated, and 
ask them to take a deep breath (valsalva manoeuvre) and hold until integrity of line is re-
established. (if catheter clamp is used or bung is in place there is no need to lay the 
patient flat or have them take a deep breath)
23. If catheter clamp is not present, connect one Luer lock needleless cap during infusion set 
change.
24. Connect new IV administration sets using Aseptic non-touch technique.
25. Ensure patient is comfortable.
26. Discard equipment appropriately
27. Document procedure in patient’s health care record noting the external catheter length 
before and after procedure. If a swab was taken, ensure forms are completed by Medical 
Officer, the specimen labelled correctly, and the site from which it was collected is 
documented on the request prior to sending to Pathology.

2.2 **Flushing and Locking of Lumens (Maintenance of Device Patency)**

**Equipment**
- Kidney Dish
- 5mL syringes for aspirating lumen(s) to be flushed/locked
- 10-20mL syringe(s) - One required for each lumen
- Sterile 0.9% Sodium Chloride for injection (Normal Saline) 10mL ampoule(s) or 
prefilled 10ml Sterile 0.9% Sodium Chloride for injection Syringes – one for each 
lumen for flushing and locking or Heparin 50 units in 5 mL if prescribed for locking 
only with 2mLs per lumen
- Luer lock needle free access device/connector(s)
- 0.5% or 2% chlorhexidine in alcohol 70% swabs , single use x number of lumens to 
be locked/flushed
- Gloves appropriate for hand size
- Mask, gown and protective eye wear
- Heparin 5000 Units in 5mLs (Vascath only) which is available from Pharmacy. Must 
be prescribed on the Medication Chart.
- 2mL syringes for each lumen volume of Heparin
1. Assess function and need for CVAD
2. Inform patient of procedure
3. Position patient to allow easy access to line
4. Wash hands
5. Prepare equipment
6. Wear Personal protective equipment (gown, mask, eyewear)
7. Wash hands with appropriate antiseptic – as per Hand Hygiene Policy
8. Apply gloves (Aseptic non-touch technique)
9. Draw up 10mL Sterile 0.9% Sodium Chloride for injection for each lumen to be flushed/locked or use Sterile prefilled syringes
10. Remove administration set / needle free access device(s) if applicable
11. Hold lumen with gauze square and clean tip of lumen vigorously with 0.5% or 2% in alcohol 70% (0.5% Solution or 2% Swab sticks) (Scrub the Hub principle)
12. Wait 15 seconds for alcohol/antiseptic to have effect
13. Applies and uses needle free connectors correctly depending on their function.
14. If catheter previously locked with heparin attach 5ml syringe to aspirate and discard 2mls (vascath only).
15. Attach 0.9% sodium Chloride flush syringe. Aspirate to check for venous return. Only draw blood into clear section of CVC lumen, not into syringe, which contaminates flush solution.
16. Flush lumen with Sterile 0.9% Sodium Chloride for injection 10-20mLs using a forceful positive pressure pulsatile flushing technique (to clear debris from lumen).
17. Clamp catheter according to type of connector in use (See appendix 5)
18. **If moderate resistance is met, stop immediately**, reclamp lumen and notify CNC, Central Venous Access and PN / patient's treating medical team during business hours. Call ICU Registrar on duty for review after-hours.
19. Repeat above steps for each lumen that requires flushing/locking.
20. If heparin prescribed for locking each lumen following 0.9% sodium chloride for injection flush use no more than 2 mLs per lumen. (Lumen volume is visible on the catheter hubs and is usually 1.5 to 1.7 ml. Check strength of Heparin as CVADS use 50 units per 5 mL and Vascaths use 5000 units in 5mL.
21. Clamps unused lumen appropriately after all accessing.
22. Discard all equipment appropriately.
23. **Document** procedure in patient's health care record and sign medication chart if heparin was used.

3. **Performance measures**
   Incidents are reported using the Incident Information Management System (IIMS) which is monitored and reviewed by appropriate Department Managers.

4. **References**

8. Infusion Nursing Standards of Practice, Intravenous Nurses Society, (2011) Jan/Feb, Volume 34 • Number 1S


12. NSW Health PD2012_007 User applied Labelling of Injectable Medicines, Fluids and Lines

Author/ Lead Reviewer: CNC Central Venous Access and Parenteral Nutrition

Reviewers: CNC Central Venous Access and Parenteral Nutrition, Staff Specialist– ICU, Drug Policy and Practice Review Committee, CNC After Hours; Infection Prevention Unit

Endorsed by: Liverpool Policy and Guideline Committee – May 2015
Appendix 1

Aseptic Technique Definition Guideline

**Key parts** must be protected and kept sterile at all times

**Key sites can** be rendered aseptically clean and not manipulated with hands

**Aseptic fields** used when key parts and key sites has to be manipulated by hand wearing sterile gloves (urinary catheter insertion, complex wound care)

**Critical micro aseptic fields** when key parts are easily protected (caps, covers, packaging)

**General aseptic fields** for promoting rather than ensuring asepsis, all key parts are well protected

**Aseptic Non Touch Technique** is used when all key sites and key parts are easily protected. A general aseptic field with critical micro aseptic fields is used with this technique (Accessing lines)

**Aseptic Technique (Surgical Asepsis)** is used when key site and key part protection and no hand contact cannot be guaranteed. A critical aseptic field and sterile gloves are used with this technique (Wound care, Urinary catheterisation)

**Sterile Technique** is used for procedures generally associated with Theatre where a surgical scrub and full barrier precautions are put in place for performing procedure (PICC lines)
Appendix 2

Application of Non-suturing Securement Device for CVADs

The Grip-Lok is a non-suturing catheter securement device that provides a foam cut insert that matches shape of the catheter hub for proper positioning and additional securement stability of the CVAD.

Application of Grip-Lok for PICC & CVC Securement

Grip-Lok 3303MCST is a catheter stabilization device that is strong enough to lock catheters securely in place, yet versatile enough for almost every patient. The Grip-Lok CS provides a foam die-cut insert that matches the shape of the catheter hub for proper positioning and additional securement stability.

- Soft and flexible fabric design improves patient comfort.
- Provides superior securement for both horizontal and vertical lifting accidental line pulls.
- Simple to apply, inspect and adjust.
- Hypoallergenic, breathable and latex-free to reduce the risk of allergic reactions and skin irritation.

Prepare the skin according to the standard hospital protocol for dressing application. Skin prep or hair removal may be required on some patients for better adhesion.

1. Open the top flap and slide the Grip-Lok under catheter hub. Position the catheter hub down into the foam cut-out and press gently to the adhesive.

2. Pull and remove one side of the bottom release liner while holding Grip-Lok in position. Then pull and remove the other side of the bottom release liner.

3. Pull and remove the inner release liner under the top flap to expose adhesive.

4. Secure the top strap over the catheter hub and press the adhesive in place. The top strap can be peeled back to inspect and adjust the catheter hub.

Grip-Lok CS for Arrow PICC/ CVC securement will also fit alternative catheter attachment points and other catheters.
Appendix 3
CVAD Dressing Examples
3M Tegaderm and Smith+Nephew IV3000 products are used in the Liverpool LHD and either dressing will provide the correct securement and protection requirements. Clinicians may use either stocked product but must follow manufacturer's application recommendations and guidelines to optimise protection and securement.
Appendix 4

Medication Administration Set Labeling Requirements

Line label / Medicine

CENTRAL VENOUS
Line inserted: Date Time

Label near the injection port on the patient side. Label adjacent to route label.
Appendix 5
Positive Pressure Pulsatile flush

Use the Scrub the Hub principle with a Chlorhexidine/alcohol antiseptic swab for a minimum of 15 seconds prior to accessing the device.

Attach prefilled flush syringe to needle free access device and flush using positive pressure pulsatile flushing technique (push/pause/push)
Clamp catheter lumen BEFORE end of flush completed and disconnect syringe – repeat scrub the hub for 5 seconds after disconnection of syringe.

**NB:** Where a negative displacement IV connector is used, clamping of lumen is required whilst flushing. For neutral connectors clamping of lumen is optional. For positive displacement connectors clamping of lumen is not required.
## APPENDIX 6 Nursing and Midwifery Accreditation Process

### Dressing of a Central Venous Access Device (CVAD) - Assessment

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Ward</th>
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</table>

**Compulsory Pre-reading of the current** Liverpool Hospital Policy C03.16 must be completed before proceeding with the assessment.

I have read and understood all information associated with the Central Venous Access Device and agree to act within the Liverpool Hospital Policy C03.16 Central Venous Access Devices (CVAD): Care and Management (which will be updated as required).

Participants Signature: ________________________                    Date:  __/__/__

**Requirements**: The following criteria must be successfully achieved during supervised assessment on one (1) occasion under the supervision of an accredited CNC/CNE/ CNS or Nominated RN. All unsuccessful attempts must also be recorded.

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Place a tick ✓ for successful criteria.</td>
<td></td>
</tr>
<tr>
<td>Identifies need for procedure &amp; patient correctly</td>
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<tr>
<td>Explains procedure to patient</td>
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<tr>
<td>Performs hand hygiene</td>
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<tr>
<td>Assembles equipment for procedure</td>
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</tr>
<tr>
<td>Applies Personal protective equipment (apron, mask and eyewear and gloves)</td>
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<tr>
<td>Assesses insertion site for tenderness, redness, swelling or drainage/discharge</td>
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<tr>
<td>Removes existing dressing and disposes of appropriately</td>
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<tr>
<td>Removes stabilisation device</td>
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<tr>
<td><em>If using non-sterile antiseptic swab sticks to clean skin this step should be performed now. Further cleaning steps can be omitted.</em></td>
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<td>Removes gloves and performs procedural hand wash</td>
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<td>Applies sterile gloves</td>
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<tr>
<td>Cleans skin around CVAD with antiseptic solution; allow to dry completely</td>
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<tr>
<td>a) Chlorhexidine/alcohol solution (preferred): apply using back &amp; forth motion for at least 30 seconds with friction to the skins surface.</td>
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<tr>
<td>b) Povidone-Iodine solution: apply using swab sticks in concentric circles moving outwards from insertion site. Allow 2 minutes to dry completely.</td>
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<tr>
<td>Maintains aseptic technique during procedure</td>
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<tr>
<td>Measures external length of catheter using markings on catheter</td>
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<tr>
<td>Applies antimicrobial dressing to insertion site as per manufacturer’s instructions</td>
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<tr>
<td>Applies securement device, surgical strips or sterile tape as per manufacturer’s instructions/hospital policy</td>
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<tr>
<td>Applies TSM dressing of appropriate size to insertion site</td>
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<tr>
<td>Discard used equipment in appropriate disposable bins</td>
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<tr>
<td>Removes gloves and discards</td>
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<tr>
<td>Performs hand hygiene</td>
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<tr>
<td>Label dressing with date and initials of procedural nurse</td>
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<tr>
<td>Performs hand hygiene</td>
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<tr>
<td>Document in the patients clinical record or in patients eMR</td>
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</table>

**Date** | **Assessor: Name/ Position / Ward**
---|---
Successful | Unsuccessful: Reassessment arranged for
Compulsory Pre-reading of the current Liverpool Hospital Policy C03.16 must be completed before proceeding with the assessment.

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Participants Signature: ________________________                    Date:  __/__/__

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Place a tick ✓ for successful criteria.

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<tbody>
<tr>
<td>Identifies need for procedure</td>
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<td>Identifies patient correctly</td>
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<tr>
<td>Explains procedure to patient</td>
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<tr>
<td>Assesses Site</td>
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<td>Performs hand hygiene</td>
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<tr>
<td>Prepares equipment and work area appropriately</td>
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<tr>
<td>Performs hand hygiene</td>
<td></td>
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<tr>
<td>Dons Personal Protective Equipment (gown, goggles, gloves)</td>
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<tr>
<td>Disinfect needleless connector with antiseptic wipe using scrub the hub principle for 15 seconds (or 30 back/forth twists)</td>
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<tr>
<td>Attach syringe of 0.9% sodium chloride to needle free connector while maintaining sterility of syringe tip</td>
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<tr>
<td>Open CVAD clamp if present</td>
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<tr>
<td>Slowly aspirate until blood return is seen in clear part of CVAD lumen</td>
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<tr>
<td>Using a pulsatile flush technique, flush lumen(s) with 10mls 0.9% sodium chloride for injection, noting any resistance or sluggishness during process. Clamp according to the type of needless connector in use as describe in policy (negative, neutral, positive)</td>
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<tr>
<td>Remove syringe and discard</td>
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<tr>
<td>Administer prescribed infusate or proceed to locking procedure</td>
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Locking Procedure

<table>
<thead>
<tr>
<th>Requirement</th>
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<tr>
<td>Check Medication Chart if Heparin locking is prescribed. Heparin ampoule and medication chart is checked by a second RN/RM.</td>
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<tr>
<td>Disinfect needleless connector with antiseptic wipe using scrub the hub principle for 15 seconds (or 30 back/forth twists)</td>
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<tr>
<td>Attach syringe of locking solution to needle free connector while maintaining sterility of syringe tip</td>
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<tr>
<td>Slowly inject locking solution, noting any resistance or sluggishness during process</td>
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<tr>
<td>Follow clamping sequence for type of needless connector in use (see policy) to reduce reflux of blood</td>
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<tr>
<td>Remove syringe and discard used equipment in appropriate disposable bins</td>
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<tr>
<td>Removes gloves and discards</td>
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<tr>
<td>Performs hand Hygiene</td>
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<td>Document in the patients clinical record or in patients eMR</td>
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Date | Assessor: Name/ Position / Ward
---|-----------------------------------

Successful | Unsuccessful:  Reassessment arranged for
Blood collection via CVAD - Assessment

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Participants Signature: ________________________                    Date:  __/__/__

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<tr>
<td>Identifies need for procedure</td>
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<td></td>
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<tr>
<td>Performs hand hygiene</td>
<td></td>
</tr>
<tr>
<td>Prepares work area appropriately</td>
<td></td>
</tr>
<tr>
<td>Applies Personal protective equipment (gown, eyewear, gloves)</td>
<td></td>
</tr>
<tr>
<td>Discontinue administration of infusates prior to obtaining blood samples</td>
<td></td>
</tr>
<tr>
<td>Maintains aseptic non touch technique (ANTT)</td>
<td></td>
</tr>
<tr>
<td>Disinfect needleless connector with antiseptic solution; allow to dry completely</td>
<td></td>
</tr>
<tr>
<td>Throughout procedure wipes lumen end/cap with Chlorhexidine/Alcohol solution before attaching each new piece of equipment</td>
<td></td>
</tr>
<tr>
<td>Attaches VACUETTE/syringe to lumen</td>
<td></td>
</tr>
<tr>
<td>Obtain discard sample - first 5mls of blood (unless for blood cultures)</td>
<td></td>
</tr>
<tr>
<td>Collects blood in required specimen tube(s)</td>
<td></td>
</tr>
<tr>
<td>Disconnects VACUETTE/syringe</td>
<td></td>
</tr>
<tr>
<td>Uses pulsating method to flush CVAD with 10-20mls of Sodium Chloride for injection (see Accessing/De-Accessing Procedure)</td>
<td></td>
</tr>
<tr>
<td>Transfer blood samples from syringe(s) to appropriate blood specimen tubes, if applicable</td>
<td></td>
</tr>
<tr>
<td>Change needleless connector according to manufacturer’s directions for use or organizational policy</td>
<td></td>
</tr>
<tr>
<td>Connects new administration set appropriately or locks with 2mls of locking solution</td>
<td></td>
</tr>
<tr>
<td>Disposes of equipment appropriately</td>
<td></td>
</tr>
<tr>
<td>Performs hand hygiene</td>
<td></td>
</tr>
<tr>
<td>Labels specimen tubes appropriately</td>
<td></td>
</tr>
<tr>
<td>Sends specimen tubes and signed request form to pathology</td>
<td></td>
</tr>
<tr>
<td>Documents procedure appropriately</td>
<td></td>
</tr>
</tbody>
</table>

Successful: ____________________________________________________________________

Unsuccessful: ____________________________________________________________________

Reassessment arranged for
<table>
<thead>
<tr>
<th>Name of staff member: ________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Number: ____________</td>
</tr>
</tbody>
</table>

1. **Pre-reading Completed**
   I have read and understood all information associated with the CVAD Policy (this will be updated as required).
   Participants Signature: __________________  Date: __/__/__

2. **Support of Nurse Unit Manager**
   I have reviewed the completed clinical assessment checklist and I am supportive of this staff member being accredited for (✓ tick all relevant):
   - [ ] Dressing of CVAD
   - [ ] Accessing of CVAD
   - [ ] Blood collection via CVAD.

   Manager/NUMs Name: ____________
   Signature: _______________  Date __/__/__

<table>
<thead>
<tr>
<th>Record of Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>To be completed by the Department Manager/ Delegated CNE/ CNC</td>
</tr>
</tbody>
</table>

- [ ] All assessment requirements have been successfully completed and signed.
- [ ] Assessment has been recorded in the ward/ department by the NUM/ CNE

- A complete copy of the ‘Record of Completion’ to be provided to:
  - The employee for their own records

Nurse Unit Manager/ Department Manager/Delegated CNE/CNC:
Name: __________________ Signature __________________ Date __/__/__
Designation: _____________________________