Site Dressing of a Central Venous Catheter (CVC)  CP/Proc/I2.4.1

Subject:  Central Venous Catheter
Area:  Intravenous Access
Classification:  Clinical Practice
Relevant to:  All Clinical Staff
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Responsible for Review:  Clinical Practice Committee
Approved by:  Executive Director
Distribution:  All Clinical Units
Location:  Clinical Practice Manual

Prior to performing the procedure refer to Central Venous Catheters, CP/Pol/I2.4, or Vascular Catheters, CP/Pol/I2.4.4, whichever is applicable, for related policy.

1.0 PRINCIPLES

1.1 Central Venous Catheters (CVCs) will be dressed according to the following practice principles:
   - Patient consent
   - Patient privacy
   - Aseptic technique
   - Patient comfort and safety
   - Standard Precautions

1.2 Registered Nurses (RNs) who have demonstrated competency in CVC site dressing as per CP/Pol/I2.4, point 6.3, are permitted to perform the procedure independently. Prior to the demonstration of competency, supervision is required as per CP/Pol/I2.4, point 6.3.
2.0 APPLICATION OF PRINCIPLES

2.1 Frequency of Dressing

2.1.1 CVC site dressings are to be attended with an occlusive dressing on Mondays and Fridays and PRN, i.e. if the occlusive dressing is lifting or if there is moisture under the dressing (CP/Pol/I2.4).

2.2 Equipment

2.2.1 Non-sterile gloves

2.2.2 Protective faceshield

2.2.3 Basic dressing pack

2.2.4 70% Alcohol with 0.5 % Chlorhexidine solution

2.2.5 Transparent occlusive dressing, 10 x 14cm, e.g. Opsite IV 3000™.

2.2.6 Specimen swab and 0.9% sodium chloride, if a swab is to be taken.

2.3 Preparation

2.3.1 Prepare the sterile field.

2.3.2 Explain the procedure to the patient.

2.3.3 Place the patient in a comfortable position that allows access to the catheter site.

2.4 Procedure

2.4.1 Don faceshield. Wash hands and don gloves.

2.4.2 Remove the dressing.

2.4.3 Assess the catheter site.

2.4.3.1 Report any abnormalities, e.g. erythema, exudate, swelling, to the patient’s Medical Officer (MO) or the Clinical Nurse Consultant (CNC)/Clinical Nurse Specialist (CNS) Nutritional Support and Intravenous Therapy (NS and IVT).

2.4.3.2 If abnormalities are present, the MO or CNC/CNS NS and IVT will review the patient and prescribe/advise appropriate ongoing patient management.
2.4.3.3 If exudate is present, swab the site before proceeding and send the swab for microscopy and culture.

2.4.4 Dispose of gloves and repeat hand wash.

2.4.5 Don fresh gloves.

2.4.6 Using Alcohol/Chlorhexidine solution, clean the catheter and the 15cm x 15cm area around the catheter, working in a circular motion from inside to out. Repeat this three (3) times.

2.4.7 Allow the Alcohol/Chlorhexidine solution to air **completely**. (Wait at least one minute).

2.4.8 Using sterile forceps, loop the catheter down and around in a “C” shape. Take care not to kink the catheter.

2.4.9 Apply the occlusive dressing with the insertion site at the centre of the dressing.

2.5 **Disposal of Equipment**

2.5.1 Dispose of equipment appropriately.

2.5.2 Remove gloves and wash hands.

3.0 **DOCUMENTATION**

3.1 Adhere a sticker with the time and date of the dressing change onto the edge of the occlusive dressing.

3.2 Record the dressing change and attendance of site swab, if applicable, in the Medical Record.

3.3 Document any abnormalities observed, including actions taken and outcomes, in the Medical Record.

3.4 The MO is to document patient assessment and prescribed patient management in the Medical Record.

4.0 **CROSS-REFERENCES**


5.0 REFERENCES


NSW Health Department. (1999), Standard Precautions Infection Control Policy 99/87


6.0 ENDORSED BY

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